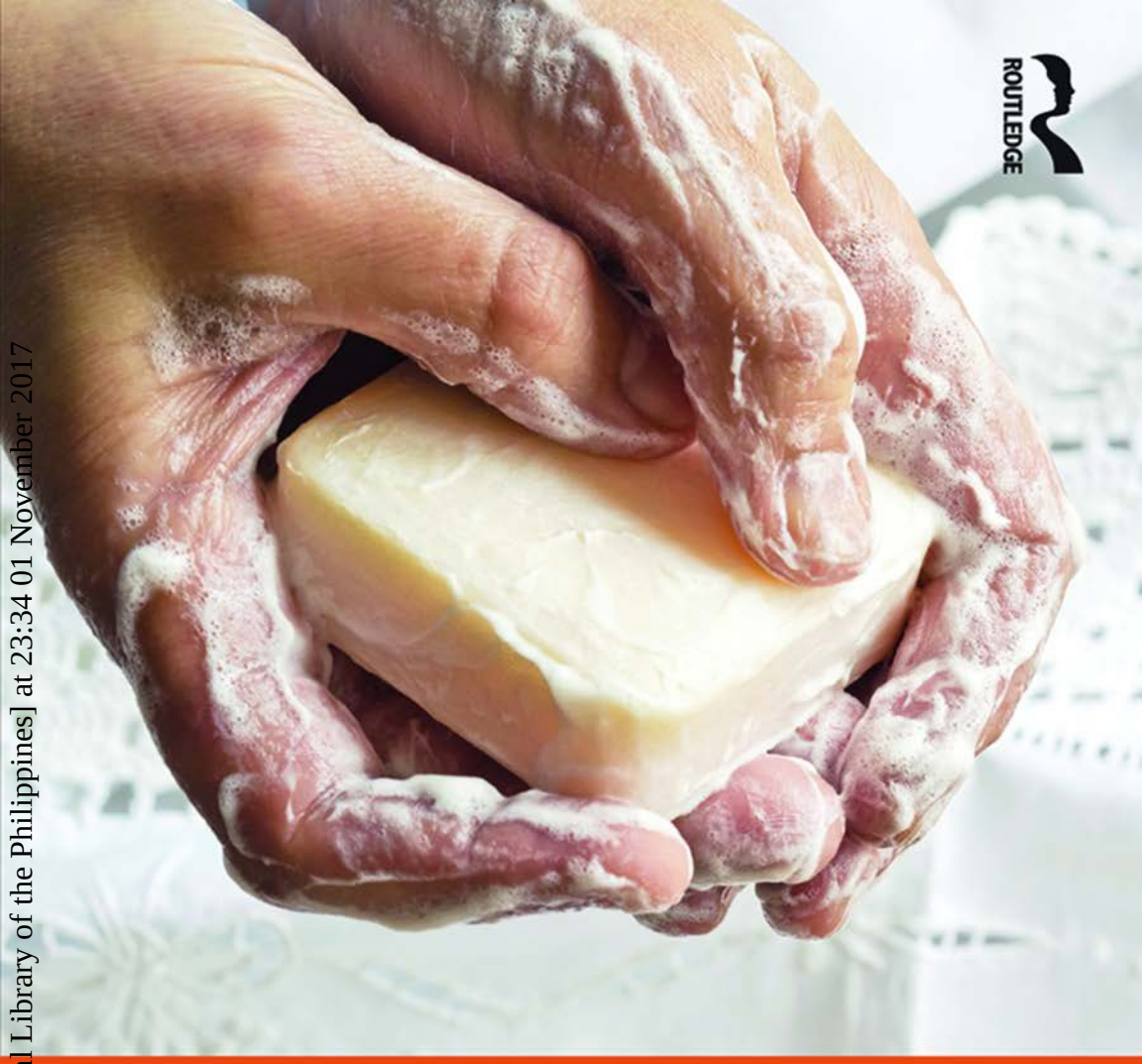

Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder

AN EXPERT CLINICIAN GUIDEBOOK

Debbie Sookman

"I strongly recommend this expert clinical guide to the psychological treatment of obsessive compulsive disorders. The depth of Dr. Sookman's clinical experience and her command of the literature are evident in the thorough coverage of assessment procedures, how to optimize the effects of therapy and deal with problems. The numerous case illustrations are well-chosen and clearly described."

—**S. Rachman**, Emeritus Professor, Institute of Psychiatry, London University, and University of British Columbia.

"*Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder: An Expert Clinician Guidebook* by Dr. Debbie Sookman is an outstanding contribution to the science and clinical practice related to the full range of Obsessive Compulsive Disorder. This is an excellent book in every way imaginable. Clearly written and organized, Sookman provides a critical and scholarly review of the state of the art on OCD. Every researcher and clinician can benefit from this superb book. The reader benefits from the considerable clinical experience and scholarship that Dr Sookman possesses, while learning specific and powerful tools in helping those who suffer from OCD. Case examples illustrate the importance of conceptualization and the value of empirically supported treatments. I am particularly impressed that Sookman was able to balance such sophistication in her critical and scientific understanding of OCD, while still writing a clear and concise book on the topic. This is a book I will recommend to both beginning clinicians in training and to seasoned researchers and practitioners."

—**Robert L. Leahy**, *Ph.D.*, Director, American Institute for Cognitive Therapy

"Dr. Sookman's book is a remarkable compilation of the current literature on Obsessive-Compulsive Disorder (OCD). Dr. Sookman emphasizes the need for evidence based treatments and elaborates what these are, how specialty cognitive behavior therapy interventions are best applied, their efficacy rates and the reasons for failure. Case illustrations make this guidebook especially compelling. I strongly recommend this expert guidebook to everyone who is interested in OCD."

—**Fugen Neziroglu,** *Ph.D., ABBP, ABPP*, Director of the Bio-Behavioral Institute, Great Neck, NY and author of numerous books including, *Overcoming Body Dysmorphic Disorder* and *Overcoming Compulsive Hoarding*, both OCD Spectrum Disorders.

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Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder

Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder is an expert clinician guide for administration of evidence-based specialized cognitive behavior therapy (CBT) for obsessive compulsive disorder and its subtypes. This book focuses on strategies to identify and resolve complex and varied reasons for resistance to CBT and to optimize symptom remission, generalize improvement, and forestall relapse during treatment for OCD. The interventions discussed build upon and elaborate the clinical and research work of other OCD experts, clinicians, and researchers in the field of cognitive therapy, and are based on the author's own research and clinical experience as an internationally known expert treating thousands of OCD patients. Criteria are outlined for symptom recovery and for treatment resistance in the context of optimal evidence-based specialized CBT delivery. Featuring treatment models and illustrative case studies, this book is a necessary addition to the library of mental health professionals who work with patients suffering from OCD.

Debbie Sookman, PhD, is Director of the Obsessive Compulsive Disorder (OCD) Clinic, Department of Psychology, McGill University Health Centre, Associate Professor, Department of Psychiatry, McGill University, Montreal, Canada, and President of The Canadian Institute for Obsessive Compulsive Disorders (CIOCD, www.ciocd.ca). Dr. Sookman is an internationally known expert in specialty assessment and treatment for OCD and Related Disorders and is a Fellow and Certified Trainer/Consultant of the Academy of Cognitive Therapy, USA.

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An Expert Clinician Guidebook

Debbie Sookman

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In loving memory of my parents Bella and Larry Sookman,
to my partner Arthur Landa with deep appreciation
for your love and inspiration,
to the many helpful and supportive colleagues from
whom I have learned,
and to the thousands of persons suffering from
this disabling
disorder who sought my help

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Contents

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Chapter 1

Introduction

> No issue facing the field, however, is as daunting and important as the dissemination crisis, since failure to improve access to care is a threat to the relevance of all of the psychological treatments of established efficacy for OCD.
>
> (Franklin & Foa, 2011, p. 238)

The aim of this book is to describe and illustrate specialized evidence-based cognitive behavior therapy for obsessive-compulsive disorder (OCD). This chapter describes an overview of the phenomenology, symptoms, and specialized treatment that are elaborated in subsequent chapters. Select issues relevant to treatment decisions facing clinicians treating this disabling disorder will be addressed. Symptoms of obsessive-compulsive related disorders will be briefly mentioned but are not the focus. Importantly, no guidebook is a substitute for systematized training that comprises didactics and supervised clinical practice. Training and supervision with an OCD expert are recommended of sufficient duration and scope to achieve specialty-level knowledge and clinical competency with varied OCD presentations.

About OCD

The World Health Organization (2008) ranks OCD as a leading cause of disability worldwide. Affecting approximately 3% of the population through the life span, the risk of occurrence and long-term persistence is substantial (de Bruijn, Beun, de Graaf, Have, & Denys, 2010; Peris et al.,

2010). OCD affects all cultural groups and substantially impacts youth. In approximately two-thirds of cases, onset is by age 22 (Fineberg et al., 2013a). OCD is recognized as a major mental illness in which sufferers experience impaired functioning across domains on par with major physical illnesses (Koran, Thienemann, and Davenport, 1996). The disabling effect on psychosocial functioning compares with that of schizophrenia, considered to be the most severe of mental disorders that affect youth (Bystritsky et al., 2001). Depression, anxiety, and hopelessness secondary to OCD symptoms are common and further increase the impact of symptoms. However, OCD is poorly recognized, and there are insufficient clinicians experienced with evaluation and treatment of the disorder, which leads to substantial treatment delay, progression to serious illness, and high rates of treatment resistance due to intervention inadequacies (Dell'Osso, Buoli, Hollander, & Altamura, 2010). Severity and chronicity of illness are associated with high health-care costs and hospitalizations (Drummond et al., 2008). Approximately 25% of these cases attempt suicide (Kamath, Reddy, Kandavel, 2007). Comorbid major depressive disorder (to be distinguished from secondary depression) augments the risk.

In the new fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, known as DSM-5 (American Psychiatric Association, 2013), OCD and Related Disorders are a separate classification, no longer classified with Anxiety Disorders. This development represents major progress in diagnosis, reflecting convergent research that indicates OCD is distinctive in terms of psychopathology and treatment requirements. Treatment for enduring or complex OCD constitutes a specialized field. There is considerable heterogeneity of symptom subtypes that each require specific interventions (Sookman, Abramowitz, Calamari, Wilhelm, & McKay, 2005). These will be summarized and illustrated in subsequent chapters.

OCD is associated with seriously reduced quality of life as well as high levels of psychosocial impairment (Hollander et al., 1996). Impairment occurs across many different domains of life (such as basic self-care and parenting, intra-familial and social functioning, capacity for school or work) and severely restricts functioning. Eisen et al. (2006) found that one-third of their treatment-seeking sample was unable to work due to

their OCD symptoms. Degree of impairment increases dramatically for people whose symptoms are in the moderate or higher level of severity: i.e., Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score of 20+, (Goodman et al., 1989). For example, obsessions about harm can make relationships with family and friends feel dangerous, with resultant social withdrawal and isolation. Intrusions about the need to be perfect interfere with completion of school or work projects, resulting in school failure or job loss. Individuals with contamination fears may avoid doctors' offices and hospitals because they fear exposure to germs, or they may develop dermatological problems such as bleeding and skin lesions due to bathing with bleach in order to feel "clean enough." Children and adolescents avoid socializing with peers and may be unable to attend school, with multiple long-term impacts (Hollander, Stein, Fineberg, & Legault, 2010). Young adults struggle or fail when they try to leave home to live independently. Many individuals impose ritualistic rules and prohibitions on family members (such as repeatedly cleaning every object that enters the home, with no visitors allowed for fear of contamination), which are associated with high levels of family dysfunction. Parents and significant others report feeling burdened by accommodation to a severe mental disorder and also frequently report high levels of distress. Impoverished quality of life for many sufferers as well as their families is devastating and constitutes a significant burden for society.

There is robust evidence that early detection and prompt evidence-based treatment of OCD can improve recovery rates (e.g., Hollander et al., 2010). Among the best predictors of long-term outcome is degree of improvement at posttreatment (O'Sullivan, Noshirvani, Marks, Monteiro, & Lelliot, 1991; Leonard et al., 1993; Foa et al., 2013). Symptom alleviation is associated with an improvement in quality of life (Bystritsky et al., 1999, 2001; Cordioloi et al., 2003; Tenney, Denys, van Megen, Glas, & Westenberg, 2003; Diefenbach, Abramowitz, Norberg, & Tolin, 2007). Early establishment of *accurate diagnosis* before the illness becomes entrenched and *effective intervention* would represent a major health-care advance. The aim of evidence-based treatment for OCD, as for other disorders, is sustained symptom recovery. Suboptimally treated OCD is associated with severe functional impairment across a broad range of functional and health-related quality of life domains, and

impaired professional and socioeconomic status (Hollander et al., 2010). Without timely specialized treatment, remission rates among adults are low (approximately 20%, Skoog & Skoog, 1999; Bloch et al., 2009).

Education and training of primary health-care professionals and mental-health practitioners is crucial to increase early detection and accurate diagnosis of OCD throughout the life span, and to promote early intervention and appropriate referral. However, an urgent difficulty in this field is that although evidence-based treatments have been developed, these are not accessible to many sufferers because there are insufficient clinicians and clinical sites experienced with assessment and treatment of this disorder. In many regions there are long waiting lists to access care that may not be evidence based (e.g., Illing, Davies, & Shlik, 2011; Szymanski, 2012). Lengthy delays in accurate diagnosis, misdiagnosis, and unavailability of specialty treatment is most dire in remote regions but is also widespread in urban centers with long waiting periods due to insufficient staff and resources. In a survey of use of specialist services for OCD and Body Dysmorphic Disorder (BDD) in the UK, patients wait approximately 20 years from first diagnosis to receiving highly specialized treatment, with devastating consequences in terms of progression of illness to disability (Drummond, Fineberg, Heyman, Veale, & Jessop, 2013). In a national US survey of office-based practice, only 39% of visits included psychotherapy (Patel et al., 2014).

The first-line evidence-based psychotherapeutic treatment of choice for OCD is specialized cognitive behavior therapy (CBT), including exposure and response prevention (ERP). Analyses of more than 24 randomized, controlled trials have shown that approximately 60–85% of patients report a substantial reduction in symptoms following ERP, with improvement maintained at 5-year follow-up for the majority of treatment responders (Ponniah, Magiati, & Hollon, 2013). Most experts recommend that cognitive therapy and behavioral experiments be combined with ERP in CBT evidence-based approaches for OCD (e.g., Grant, 2014). However, research indicates that the "majority" of individuals with OCD do not receive optimal specialty CBT treatment for their symptoms (Shafran et al., 2009). This clinical reality has been cogently elaborated by several authors (e.g., Franklin & Foa, 2011). Research indicates that clinicians report using CBT for OCD, and patients report receiving it, but

the content of sessions often does not resemble evidence-based protocols (Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). This may be because training in general psychiatry, psychology, and/or CBT are not necessarily sufficient to acquire the specialized clinical skills required for evidence-based best practice for treating complex OCD. Academic training programs that offer longer-term rotations in the treatment of OCD as an elective are desirable, to ensure that the next generation of clinicians is adequately equipped and that sufficient qualified supervisors are available to teach this greatly needed expertise. Improvement of existing models of continuing education and training to disseminate *advanced* specialty clinical skills is required to optimize illness recovery, and to ensure that clinicians are not practicing with inadequate clinical skills (Sookman & Fineberg, 2015).

Pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs) is the first-line evidence-based pharmacological treatment of choice (Koran & Simpson, 2013). Treatment should be optimally delivered at maximal tolerated dose levels with assessment of adherence. Sustained treatment may protect against relapse (Fineberg, Brown, Reghunandanan, & Pampaloni, 2012, Fineberg et al., 2013b; Fineberg et al., in press). Duration of suboptimally treated illness impacts adversely on response to pharmacotherapy, also underlining the need for effective and timely intervention. The evidence on efficacy of combined treatment with CBT and medication is reviewed in this chapter. Adjunctive treatment with medication acting differently from SSRIs, such as low-dose antipsychotics, or newer pharmacological compounds, may be helpful in treatment-resistant cases.

It has been emphasized by experts that the OCD patient have access to care at a level appropriate to his/her treatment needs. The application of optimal treatment, in terms of intensity and specificity, is recommended to avert unnecessary deterioration to chronicity, disability, intransigence of symptoms, ineffective health-care utilization, and erroneous labeling as "treatment resistant." Patients who show an incomplete treatment response, that is those who remain ritualistic following treatment, remain susceptible to relapse. Training of primary health-care professionals and general mental-health practitioners is crucial to increase early detection, accurate diagnosis, and appropriate referral

for treatment of OCD throughout the life span. Early referral to a specialist center may represent the cost-effective option for OCD patients regardless of illness severity (i.e., for less severely ill patients as well), as specialized treatment would be expected to increase the rate of response and recovery. In response to limited resources, "stepped care" models have been proposed that would involve many patients being offered low-intensity treatment as a first step in the pathway of care. However, these pathways have not so far been sufficiently empirically validated for OCD and Related Disorders and run the serious risk of undertreating the disorder (Sookman & Fineberg, 2015).

Clinical Symptoms of OCD

Obsessions are repetitive intrusive thoughts (e.g., of contamination), images (e.g., of violent or horrific scenes), or abhorrent urges (e.g., to stab someone) experienced as involuntary and highly distressing. Sensations reported include feeling "not just right" and a sense of incompleteness (Summerfeldt, 2007) as well as sensorial experiences (Simpson & Reddy, 2014). Patients may report repeated involuntary intrusive thoughts, images, or memories about past events about which they have strong feelings (e.g., guilt or anger) that include "every detail." Rituals are repetitive behaviors (e.g., washing, checking) or mental acts (e.g., repeating or replacing words or images) carried out in response to an obsession in order to reduce distress or to prevent a feared event (e.g., becoming ill). Rituals are not connected realistically to feared events (e.g., arranging items perfectly to prevent harm to a loved one) or are clearly excessive (e.g., showering for five hours daily with seven repetitions on every body part). In most cases insight is retained: the individual recognizes his/her beliefs and fears are unrealistic. Mild to moderate illness involves 1–3 hours per day obsessing or doing compulsions, however, many individuals experience virtually constant distressing intrusive thoughts and rituals that are incapacitating. Up to 30% of individuals with OCD have a lifetime tic disorder, most commonly in males with childhood onset of OCD (please see DSM-5, APA, 2013).

Content of intrusive thoughts differs with the developmental stage of the individual. For example, there are higher rates of sexual

and religious obsessions reported by adolescents than children. Higher rates of intrusive thoughts of harm and catastrophic events, such as death or illness to self or loved ones, are reported by children and adolescents compared with adults. These themes occur across different cultures and may be associated with different neural substrates (Clark et al., 2014). Many individuals report multiple symptom subtypes. Reported distress associated with symptoms is often intense: anxiety or panic; feelings of disgust (e.g., that one's own or others' bodily fluids such as urine, menstrual blood, feces are dirty or disgusting and must be avoided); a sense of "incompleteness" or uneasiness until things feel "just right" (Summerfeldt, 2007). Feared situations that provoke intrusive thoughts and urges to ritualize are commonly avoided such as restaurants, public transportation, and restrooms in the case of washers or social situations related to fears about causing harm. The content of obsessions tend to be those that are against the moral values of the individual (Rachman, 2003).

OCD Related Disorders

Body Dysmorphic Disorder (BDD)

Approximately 8–37% (Phillips, 2000) of patients suffering from OCD also report BDD. Individuals suffering from BDD report highly distressing unrealistic beliefs and preoccupations that one or multiple aspects of their appearance are "ugly," "deformed," or "hideous." BDD is associated with checking rituals and multiple psychosocial impairments, including refusal to attend school. Prevalence of suicidal ideation and attempts attributed to appearance beliefs is high. The mean age of onset is 16–17 years, but the most common age of onset is 12–13 years. BDD has been reported to be associated with childhood neglect or abuse in some cases. Prevalence is elevated in first-degree relatives of individuals with OCD. One's view of appearance generally ranges from exaggerated in a negative direction to a wholly unrealistic view. As an example of the latter, a beautiful 21-year-old woman saw 10 physicians—including dermatologists and plastic surgeons—because she believed that small lines around her eyes meant she was "prematurely aging and ugly." Some of

these patients seek and receive surgeries for perceived deformities that unsurprisingly often do not meet with the patient's satisfaction. Specialized assessment and treatment is important prior to and instead of elective surgeries for these patients (please see DSM-5, APA, 2013 for description of OCD Related Disorders).

Trichotillomania

Trichotillomania, or hair pulling, generally develops during puberty and is associated with severe distress and social and school impairment. Hair pulling can occur in single or multiple areas including the head, eyelashes, and brows, and less often other parts of the body such as arms, legs, or the abdomen. In severe cases there are obvious bald spots on the patient's head and an absence of eyelashes. The patient may wear hair attachments or wigs and may conceal their behavior, including avoidance of intimacy. Varied stressors such as work or school and interpersonal issues may exacerbate symptoms, but symptoms may develop a "functionally autonomous" habitual pattern as well. There may be irreversible damage to hair growth and hair quality. Infrequent medical consequences include digit purpura, musculoskeletal injury (e.g., carpal tunnel syndrome; back, shoulder, and neck pain), blepharitis, and dental damage (e.g., worn or broken teeth due to hair biting). Rarely, swallowing of hair may lead to trichobezoars, with subsequent anemia, abdominal pain, hematemesis, nausea and vomiting, and bowel obstruction (APA, 2013).

Excoriation Disorder

Excoriation (skin-picking) disorder involves recurrent picking at one's own skin for significant amounts of time, usually several hours daily. As is common for untreated obsessive-compulsive and related disorders, symptoms may endure for years. Three-quarters of sufferers are girls, with onset during adolescence at puberty. The disorder often begins with a dermatological condition such as acne. Sites of skin picking are multiple and the usual course is chronic if untreated. A significant proportion of students report missing school and difficulties studying secondary to picking. Some patients report hours of rituals and can delineate their

specific picking protocols. Medical complications include tissue damage, scarring, and (rarely) infection that can be life threatening. Antibiotic treatment for infection is frequently required. Occasionally surgery is required (APA, 2013).

Hoarding Disorder

Hoarding Disorder is characterized by persistent difficulties discarding possessions, regardless of their actual value, and excessive accumulation. Items create clutter to the point where living areas are no longer usable. For example, the individual may not be able to cook in the kitchen, sleep in bed, or sit in a chair. Clutter impairs basic activities such as moving through the house, cooking, cleaning, personal hygiene, and sleeping. Appliances may be broken and utilities such as water and electricity may be disconnected, as access for repair work may be difficult. Quality of life is often seriously impaired. Unsanitary conditions and risk of fire can result. For example, papers and other objects may be piled almost to the ceiling with heating elements covered and route to windows blocked. Concealment, denial of the seriousness of the problem, and poor insight are not uncommon. Rarely, hoarding can be life threatening: two hoarding patients in Canada froze to death when their heating stopped during winter and they did not call their landlord for fear of discovery and eviction. Intervention of third parties is often required (e.g., family members, cleaners, local authorities). Other common features of hoarding disorder include indecisiveness, perfectionism, avoidance, difficulty planning and organizing tasks, excessive attachment to possessions ("they remind me of an important time in my life" or "I may need it one day and don't care if it's on the Internet"), and social isolation. Hoarding symptoms first emerge around ages 11–15 years and start interfering with the individual's daily functioning by the mid-20s. Untreated hoarding shows a progressively worsening course. When parents are seriously afflicted Youth Protection Services are often involved to remove the child from an unlivable environment. Specialized treatment approaches for hoarding have been developed and examined in numerous publications (e.g., Tolin, Frost, & Steketee, 2007; Steketee & Frost, 2014).

Summary of Central Theoretical and Treatment Issues in Assessment, Treatment, and Research of OCD

This section summarizes several key issues relevant to evidence-based clinical practice and controlled research that are elaborated and illustrated throughout this volume.

1. Current research indicates that treatments are not equivalent in efficacy and that the "dodo bird" hypothesis has been disconfirmed (Bell, Marcus, & Goodlad, 2013; Tolin, 2010, in press). Specific interventions are required to achieve optimal change for specific symptoms (e.g., Koran & Simpson, 2013). Nonspecific factors such as the therapeutic relationship are essential but insufficient factors in the change process; unsurprisingly, effective symptom change during CBT predicts a positive therapeutic relationship (e.g., Marker, Comer, Abramova, & Kendall, 2013). All clinicians, regardless of orientation, should be guided by current empirical research as well as their own specific areas of competence when making treatment recommendations.
2. CBT practice requires adherence to ethical guidelines prescribed for all psychotherapeutic practice. Of paramount importance, "treatment is arguably not ethical regardless of other considerations unless it is evidence-based, notwithstanding the requirement for ongoing examination of existing and novel interventions to address the heterogeneity and complexity of clinical presentations. Disorder specific evidence-based clinical practice is predicated on a sufficient number of methodologically sound RCTs that indicate that the specific treatment offered is at least equivalent to or better than other available 'bone fide' treatments" (Sookman, in press). Assessment of efficacy should be based on multidimensional change criteria including standardized measures of symptoms, general psychiatric symptoms, psychosocial functioning, and quality of life. Diagnostic and intervention competency of clinicians can be assessed using general and disorder specific validated measures (e.g., Muse & McManus, 2013).
3. The causes of OCD remain poorly understood. Childhood-onset OCD is estimated to be 45–65% heritable and OCD with an onset

during adolescence or adulthood 27–47% heritable (van Grootheest, Cath, Beekman, & Boomsma, 2005). However, although genomewide association studies have suggested candidate genes, findings have been inconsistent or require replication (Stewart et al., 2013). Many patients ask if OCD is "a problem with my brain." Ongoing translational research is important to our understanding of the neurophysiology of OCD. While several brain structures and functions have been implicated in OCD, importantly, it remains unclear if these changes are the cause or the effect of OCD symptoms. In addition to hyperactivity in the orbitofrontal cortex and caudate, other key implicated regions include the anterior cingulate cortex, thalamus, amygdala,

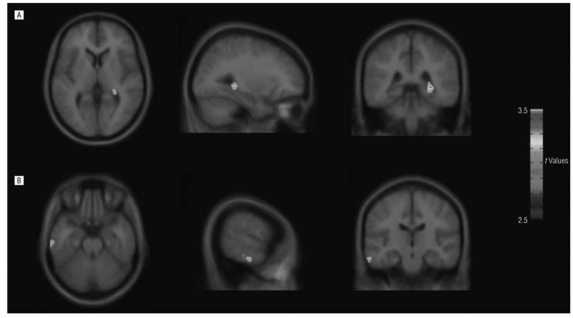

Figure 1.1. Statistical parametric maps (SPM8; Wellcome Functional Imaging Laboratory, London, England) showing brain regions where K values were significantly higher in patients with obsessive-compulsive disorder (n = 21) than in healthy controls (n = 21). The statistical t-map threshold was 2.70, with P = .005 and an extent threshold of 100 voxels. Significant clusters were found in (A) the right hippocampus (t_{40} = 3.37, k = 151 voxels, coordinates x, y, z, respectively: 30,−38, 4 mm) and (B) the left inferior temporal gyrus (t_{40} = 3.10, k = 157, coordinates x, y, z, respectively:−62,−20,−24 mm).*

and parietal cortex (Saxena & Rauch, 2000; Berney et al., 2011, Piras, Piras, Caltagirone, & Spalletta, 2013), with associated functional difficulties such as cognitive inflexibility (Chamberlain et al., 2008).

Further, research has indicated there are similar brain findings in OCD compared with normal individuals that may be only a question of magnitude. This is consistent with the well-documented finding that normal individuals experience a wide range of intrusive thoughts similar to OCD *but appraise these differently* (e.g., Mataix-Cols & van den Heuvel, 2012). Very importantly, several studies have reported robust findings that functional abnormalities on neuroimaging improve or resolve following CBT alone (e.g., Saxena et al., 2009; Lissemore et al., 2014; Morgiève et al., 2014).

4. Treatment for enduring or complex OCD is a specialized field (e.g., Fineberg et al., 2013c). Specialized CBT is the first-line evidence-based psychotherapeutic treatment of choice for OCD throughout the life span (APA, 2007; Koran & Simpson, 2013). The prognosis for OCD is suboptimal with general CBT approaches that do not target subtype-specific characteristics, resulting in significant or residual symptoms that compromise quality of life and render the individual susceptible to relapse. The prognosis for OCD is reliably poor with psychoanalytic therapy (PT), therefore, it would not be considered ethical to offer PT for this disorder.
5. Individuals suffering from OCD should seek specialized treatment as soon as possible following development of symptoms in order to avert unnecessary progression to disability and intransigence of symptoms. Stepped-care approaches have been developed with the aim of providing service commensurate with clinical need, but due to limitations in clinical knowledge and skill as well as financial limitations these run the serious risk of undertreating the disorder (Sookman & Fineberg, 2015).
6. Integral to varied interventions for OCD is the aim that the individual learn to adaptively handle—rather than avoid—feared intrusions, emotions, and external stimuli that evoke distress and symptoms. Specialized CBT for OCD comprises specific cognitive therapy and behavior therapy interventions that are combined throughout treatment *and that address subtype specific characteristics*. Cognitive

therapy aims to help the patient to identify, reappraise, and adaptively cope with distressing thoughts, feelings, and external events. Behavior therapy includes ERP and behavioral experiments (BH). Again, these approaches differ in their application according to symptom subtype. Treatment ingredients are selected to address clinical presentations that are often complex as will be described and illustrated throughout this volume.

7. Treatment is most effective when provided by a therapist with adequate educational background, training, and clinical experience with OCD. A misconceived view still expressed by some practitioners is that exposure and related interventions are "uncomplicated." Experimental and clinical research highlight complex mediators underlying successful exposure-based treatment (e.g., Bouton, 2002; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). Decisions about the content, timing, and processes may be complex, and therapists attempting this treatment require adequate training and supervision by a therapist experienced with specialized CBT for OCD (APA, 2002, 2.01[a]). This includes being prepared to handle therapeutically inevitable distress.
8. Clinicians who wish to deliver evidence-based treatments for OCD should be informed of (a) what they need to know, and (b) what they need to do (e.g., Franklin et al., 2013). The required knowledge base includes diagnostic criteria for OCD and general diagnostic criteria to assess comorbidity; theoretical literature; assessment literature, including assessment modalities (interview, behavioral observation, and standardized clinician and self-report measures); and treatment outcome literature. Required competencies include a scientist–practitioner model of practice that integrates individualized case conceptualization, knowledge of outcome research, and specialized clinical skills and experience in treatment planning and implementation for OCD of varied subtypes.
9. Accurate assessment of comorbidity requires sophisticated cross-diagnostic skill. That is, an OCD expert should also be an experienced diagnostician. Accurate early diagnosis of OCD and comorbid disorders is essential for appropriate early intervention. Given the heterogeneity of OCD, and high levels of comorbidity, clinicians

must have sufficient knowledge and experience with cross-diagnostic as well as OCD specific symptoms and related difficulties (DSM-5, APA, 2013).

10. The aim of treatment for OCD, as for any disorder, is recovery of symptoms and restoration of multidimensional quality of life for as many patients as possible. The literature indicates that individuals with OCD should receive a trial of CBT of sufficient duration and scope to optimize the possibility of recovery (e.g., Grant, 2014). Criteria proposed for an optimal trial of specialized CBT for OCD are outlined in Chapter 11 of this volume.
11. Patients with OCD should receive specialized CBT either alone or in combination with medication. In general, it is not evidence-based best practice to administer medication alone for OCD. Available research indicates the following: pharmacotherapy is required and is helpful for some individuals, however, medication for OCD is generally not curative. Pharmacotherapy plus CBT has not been found to be more effective compared with CBT alone. Adding ERP to SSRI treatment achieves significant improved treatment response (compared with adding a neuroleptic). Relapse rate is high following discontinuation of medication (even when effective) compared with medication combined with CBT (e.g., Reddy, Alur, Manjunath, Kandavel, & Math, 2010; Simpson et al., 2013). Not receiving CBT is among the variables that predicts poor outcome for OCD patients (Reddy et al., 2010).
12. A crucial distinction should be made between "technical" treatment failures, when an individual does not improve due to the inadequacy of treatment, and "serious" treatment failures when an individual does not respond to adequately delivered treatment (Rachman, 1983). In my experience, also reported by other OCD experts (e.g. Krebs & Heyman, 2010; Fineberg et al., 2013c), the majority of persons with OCD who present as being "treatment resistant" or refractory fall into the technical treatment failure category having received inadequate CBT. Common inadequacies include: inaccurate psycho-education, insufficient or incorrectly applied ERP (e.g. restricted to the office, partial ERP), sessions of inadequate duration and/or frequency, premature termination of treatment, and failure

to deliver treatment that is specific to subtype characteristics or at a developmentally appropriate level.

13. In response to specialty treatments it has been demonstrated that OCD is curable in some cases (e.g., Sookman & Pinard, 1999; Simpson, Huppert, Petkova, Foa, & Liebowitz, 2006; Belloch, Cabedo, & Carrio, 2008; Rachman, Coughtrey, Shafran, & Radomsky, 2015). Results of these studies are summarized below. Standardized criteria for treatment response, remission, recovery, and relapse are required for clinical and research purposes (e.g., Pallanti et al., 2002; Hollander & Zohar, 2004; Simpson, Franklin, Cheng, Foa, & Liebowitz, 2005; Simpson, Hubbert, Petkova, Foa, & Liebowitz, 2006). Relatively few studies have reported the percentage of patients who have improved to the status of wellness or recovery and long-term maintenance of these gains (Eddy, Dutra, Bradley, & Westen, 2004; Hollander et al., 2003; Dell'Osso et al., 2013; Bloch et al., 2013; Peris et al., 2013). Sookman & Steketee, 2010 and other authors (e.g., Belloch et al., 2008) have defined treatment recovery as no longer meeting criteria for OCD (Y-BOCS ≤ 7), that is, actual recovery from the disorder. Proposed criteria for recovery and resistance in OCD are outlined in Chapter 11.
14. There is a clear need to define what constitutes evidence-based effective and optimal treatment with replicable evidence-based protocols that include multidimensional outcomes measures, core competencies (knowledge, skills) required by clinicians to deliver these as well as optimal dissemination procedures (Sookman & Fineberg, 2015). In order to further examine recovery rates in OCD, randomized controlled trials are required that "optimize" dependent variables and interventions to address the inadequacies listed earlier. It is important to report those patients who recover (and sustain their recovery) and their characteristics, compared with patients who achieve clinical meaningful change versus those who do not achieve such gains.
15. The role of the family and/or significant others should be assessed and addressed in treatment, as these factors have an important impact on symptom severity and treatment outcome. Accommodation to OCD symptoms (e.g., participating in rituals, providing repeated reassurance) interferes with treatment efficacy

(Calvocoressi et al., 1995; Storch et al., 2010; Thompson-Hollands, Edson, Tompson, & Comer, 2014). Severity of OCD symptoms is associated with higher levels of family accommodation (Gomes et al., 2014). Significant others should therefore be routinely involved in treatment, unless contraindicated. Recommendations should be made with prior agreement by the patient, be communicated with or by the patient, and be commensurate with the patient's ongoing progress and skills.

16. Assessment and treatment should be culturally sensitive. Cultural and religious affiliations may affect the content of OCD symptoms. For example, the content of religious and or sexual obsessions varies across religious denominations and cultures (e.g., prescribed prayers, self-purification, premarital sex, homosexuality, etc.). Patients' symptoms should be understood in the context of their cultural norm (e.g., Chassidic Jewish person versus Muslim person), with pathology identified as significantly exceeding the norm. Although the themes underlying OCD appear to be similar across cultures, cultural factors do influence the content of intrusive thoughts. For reviews, please see Clark et al., 2014; Radomsky, Rachman, Shafran, Coughtrey, and Barber, 2014, and Moulding et al., 2014.
17. When the therapist is a trainee, patients must be informed of this fact and of the supervisory process (APA, 2002, Standard 10.01). Please see Rosenberg and Heimberg (2009), and Newman (2013), respectively, for a discussion of issues in the clinical supervision of doctoral psychology interns and training CBT supervisors. Supervision involves dissemination of evidence-based conceptual models and treatment skills. Methodologies should include didactic readings and seminars, clinical rounds, scientist–practitioner hypothesis generation and testing; modeling of decision making processes and criteria; clinical supervision of cases including direct observation, modeling and role playing of interventions, and co-therapy; clinical research supervision (i.e., how to integrate research and clinical practice); and the student as supervisor. Supervision involves responsibility to the profession and institution, patient care, therapist competencies, processes of supervision (i.e., cognitive and emotional experience of the supervisee during therapy and supervision) that

foster professional growth, and ongoing identification and remediation of difficulties.

18. Consent for new and untested treatments requires detailed discussion of potential risks and presentation of alternative established treatments (APA, 2002, Standard 10.01b).
19. An urgent difficulty in this field is that evidence-based effective treatments for OCD are available but these are not accessible to many sufferers because of an insufficient number of clinicians qualified to deliver these. Training in general psychiatry, psychology, and/or general CBT are not necessarily sufficient to acquire the specialized CBT skills required for evidence-based practice with complex OCD and related disorders. Additional doctoral and residency training programs in psychology and psychiatry are needed that comprise specialty treatment skills required to optimize illness recovery for these disorders. Transformative change in educational and training models is required. For example, a weekend workshop on ERP techniques is insufficient to learn to administer ERP according to evidence-based protocols. Although clinicians report using CBT, and patients report receiving it, interventions are often not consistent with evidence-based protocols (Shafran et al., 2009; Stobie et al., 2007). These common intervention problems are associated with reliably suboptimal or failed treatment outcomes, with many patients erroneously labeled as "treatment resistant" as a result of inadequate intervention.
20. Among the leading organizations involved in evidence-based CBT knowledge transfer and training to the level of advanced certification expertise, across diagnoses and specific to OCD respectively, are the Academy of Cognitive Therapy (www.academyofct.org), the British Association for Behavioural and Cognitive Psychotherapies (www.babcp.com), and The Canadian Institute for Obsessive Compulsive Disorders (CIOCD, www.ciocd.ca).

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Chapter 2

OCD Subtypes and Comorbidity

The OCD symptom dimensions most reliably identified include contamination/cleaning, doubt about harm/checking, symmetry/ordering, and unacceptable thoughts/mental rituals (Williams, Mugno, Franklin, & Faber, 2013). The OCD symptoms reported in the National Comorbidity Survey Replication epidemiological study (NCS-R; Ruscio, Stein, Chiu, & Kessler, 2010) include checking (79.3%), ordering (57.0%), moral concerns (43.0%), sexual/religious concerns (30.2%), contamination (25.7%), harming (24.2%), concerns about illness (14.3%), and other (19.0%), with 81% of respondents endorsing multiple symptoms. These findings underline the need for clinicians to flexibly utilize several approaches tailored to the patient's symptom profile, and to conduct further outcome research to refine evidence-based standards.

There are accumulating data (Leckman et al., 1994; Miguel et al., 2000; Rosario et al., 2009; Ferrão et al., 2012; Shavitt et al., 2014; Simpson & Reddy, 2014) that support broadening the conceptualization of obsessions to include sensory phenomena. For example, physically uncomfortable sensations are reported by some patients (e.g., on skin, in muscles, in head) that precede or are associated with repetitive behaviors. "Just right" experience is commonly reported as distressing and can be triggered by visual, auditory, or tactile sensations associated with rituals to make things appear and feel just right. Feelings of incompleteness are associated with repetitive behaviors in order to feel "complete" (Summerfeldt, 2007). In some cases the person links rituals to a need for "energy

release" or solely to an urge, "I have to do it" (Shavitt et al., 2014). Musical obsessions are an understudied phenomenon (Taylor et al., 2014).

Available research indicates that patients with different subtypes respond differently to specific CBT interventions. For example, it has been reported that treatment for unacceptable or taboo obsessions, which have shown a poorer response to ERP compared with other subtypes such as washing, is improved by subtype-specific cognitive therapy with behavioral experiments (Freeston et al., 1997; Sookman, Abramowitz, Calamari, Wilhelm, & McKay, 2005; Rachman, 2003, 2007; Whittal, Woody, McLean, Rachman, & Robichaud, 2010; Williams et al., 2014). Treatment for mental contamination (Rachman, 2003; Rachman et al., 2015) requires adaptions in conceptualization and approach compared with contact contamination from external stimuli such as germs. Refinement of treatment for checking behaviors involves targeting associated difficulties such as memory distrust and advocating for some patients a phase of specific safety behaviors in order to optimize reappraisals during exposure (Radomsky, Shafran, Coughtrey, & Rachman, 2010; Levy & Radomsky, 2014).

Similar symptoms have different functions and meanings across patients. For example, three patients with washing rituals reported the following: (a) "I'm afraid I might morph into people I don't like if I accidentally touch them or their stuff so I wash off whenever I've been with them"; (b) "I have to make sure all bacteria are gone from my hands so I don't make my baby sick"; and (c) "I wash to get rid of the disgusting feeling I'm contaminated. I just can't stand the feeling" (Sookman & Steketee, 2010). Checking rituals can be evoked by a variety of obsessions, including harming, sexual, or scrupulous (Feinstein, Fallon, Petkova, & Liebowitz, 2003). As Sookman and Pinard (2007) noted:

> Similar OCD symptoms have different functions for different patients (e.g., washing to prevent feared illness as opposed to reduce feelings of disgust). Symptom-related beliefs differ across symptom subtypes. For example, responsibility appraisals (Salkovskis, 1985) are characteristic of checkers with harm-related obsessions but are not characteristic of washers who describe "feeling" contaminated (OCCWG, 2001). Catastrophic misappraisal of thoughts as dangerous, specifically those viewed as contrary to one's value system (Rachman, 1998; 2003), with efforts at thought control

> (Clark, 2004), are central for many patients with obsessions. However, this aspect of psychopathology is not reported by other subtypes (e.g., some washers, hoarders). Thought–action fusion is experienced by some checkers (e.g., "If I have the thought of death, a family member will die"), but not by others (e.g., "If I don't check my stove properly, my house will burn down"). Individuals concerned with symmetry or order may report feeling a need for perfection, or rather that their symptoms are associated with a sense of incompleteness or "not just right" experiences. (Coles, Frost, Heimberg, & Rhéaume, 2003)(p. 98)

The content of repugnant obsessions falls largely into three categories: blasphemous thoughts, sexual thoughts, and thoughts of harming others. Misappraisals are reported in response to intrusive thoughts as well as emotions. For example, "the fact that I am anxious around knives proves that I am a dangerous person." Examples of religious obsessions include a fear of engaging in sacrilegious behavior in a holy place (e.g., "I will yell obscene things at the service instead of praying"), "impure" thoughts, sacrilegious images, or fear of being "misled by the devil." Sexual obsessions include fear of committing inappropriate acts or images of engaging in sexual behavior with inappropriate partners (e.g., "I will sexually molest a young girl or child"). Aggressive/harm obsessions involve fears of harming other people (e.g., "I will push an elderly person in front of a moving bus during a red light"; "I will stab my kid sister") or of harm befalling relatives or friends (e.g., "My parents will be killed by an intruder because I didn't lock the door properly"). Some obsessions comprise multiple themes such as images of committing sexual acts with religious figures (e.g., "I imagine myself having sex with the holy virgin Mary"). These themes commonly produce strong feelings of fear, guilt, shame, and self-doubt. Patients report distrusting their self-view and their integrity and morality, and they struggle with feelings that they are "unsafe, bad, weird, or on the verge of going crazy." Concealment of distressing thoughts, avoidance of triggers, as well as cognitive and behavioral rituals perpetuate their misappraisal (Rachman, 2003). A common information processing distortion is thought-action fusion (TAF, Rachman, 1993; Shafran & Rachman, 2004): "the belief that thinking about an unacceptable or disturbing event makes it more likely to happen,

and the belief that having an unacceptable thought is the moral equivalent of carrying out the unacceptable or disturbing action" (Shafran et al., 1996, p. 379). The second form of TAF, the morality bias, includes the belief that having an unacceptable thought about someone else (e.g., harming) is equivalent to actually harming them. Preventive and/or checking behavior often follow. Emotional reasoning is also a very commonly reported symptom-related processing error: "I feel scared, so I must be in danger" (Arntz, Rauner, & van den Hout, 1995).

Many patients endorse symptom-related dysfunctional beliefs characteristic of OCD (OCCWG, 2001, 2003, 2005, please see elaboration later in this chapter). However, some patients do not endorse beliefs on available cognitive scales at dysfunctional OCD levels and may not differ from normals on this dimension (Calamari et al., 2006; Taylor, Abramowitz, & McKay, 2007). These individuals report symptom-related feelings of incompleteness, "not just right" experience, or intolerance of distress without feared consequences except for fear that distress will not diminish (Coles, Heimberg, Frost, & Steketee, 2005; Summerfeldt, 2004, 2007).

Two dimensions of OCD have been proposed and examined: harm avoidance and incompleteness (Summerfeldt, Kloosterman, Antony, & Swinson, 2014). Harm avoidance includes those patients with anxious apprehension and excessive avoidance of potential threat. Incompleteness includes those patients with a sense of incompleteness or not "just right." These dimensions have been associated with different emotional responses (i.e., anxiety and urge to avert harm versus tension/discomfort and need to perform tasks until they are just right), different age of onset (later versus earlier onset), different patterns of comorbidity (e.g., anxiety disorders versus comorbid tic disorders and obsessive-compulsive personality disorder), and potentially different treatment outcome. Importantly, OCD patients can exhibit both harm avoidance and incompleteness. Although Summerfeldt et al. (2014) reported recent support for the structural validity of harm avoidance and incompleteness there is little outcome research comparing different treatments for these dimensions that require further study.

Some forms of OCD have been associated with chronic tic disorders, including Tourette syndrome, that may be etiologically linked. Data suggest that these patients may respond better to antipsychotic

augmentation of a serotonin reuptake inhibitor (SSRI) than those without tic disorder. Some children with comorbid tic disorders may have an increased likelihood of OCD remission, but this is not a consistent finding (Leckman et al., 2010).

Early onset OCD (EO, onset before puberty) has been reported in some studies to have a higher rate of OCD among relatives compared with late onset (LO), to differ in course and comorbidity, and to occur more frequently in males (Leckman et al., 2010). However, studies have confounded tic-related and EO OCD, and there are varying definitions of EO OCD. Lomax, Oldfield, & Salkovskis (2009) reported that although no differences in treatment response between EO and LO groups were found, the EO group was rated as being more severe across a range of measures at start of treatment, and thus at end of treatment, suggesting that more treatment sessions may be required for individuals who report an EO of symptoms. Given variability in trajectory of development choosing a definite age by which OCD onset is classified as early is difficult to precise. Finally, it is not clear that early onset OCD necessitates different treatment decisions (Nakatani et al., 2011). A dimensional approach to OCD symptoms may have value in genetic, biological, and treatment studies. However, dimensions are complex, most individuals with OCD report symptoms in multiple dimensions, and the symptom dimensions are not necessarily stable over time (Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002).

It has been hypothesized that some individuals develop abrupt onset of OCD symptoms and tic disorders related to an autoimmune process following group A beta-hemolytic streptococcal infection (reviewed by Leckman et al., 2010). This syndrome has been labeled "pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" (PANDAS). To date, reliable support for alternative treatments (additional to initial antibiotics) for suspected cases of PANDAS is lacking (Swedo, Leckman, & Rose, 2012). Streptococcal infection may be one of multiple causes for abrupt onset of OCD symptoms, which is now called "pediatric acute-onset neuropsychiatric syndrome" (PANS) or "childhood acute neuropsychiatric symptoms" (CANS; see Singer, Gilbert, Wolf, Mink, & Kurlan, 2011). There is a small subset of OCD patients who report posttraumatic (psychological) development of OCD

symptoms (Fontenelle et al., 2012). The heterogeneity and complexity of symptoms underline the need for conceptual and intervention models that can be flexibly tailored on an individualized basis, guided by available research.

Comorbidity in OCD has been examined extensively (e.g., Denys, Tenney, van Megen, de Geus, & Westenberg, 2004; Boschen & Drummond, 2012; Fineberg et al., 2013a). Depression is the most frequent comorbid condition. In a large sample, Denys et al., 2004, found that 27.1% reported a comorbid mood disorder characterized by earlier age of onset and greater severity of symptoms. It is important to differentiate between comorbid mood disorder and secondary depression that commonly results from disabling symptoms, distress, and impact on psychosocial functioning that remit following successful treatment of OCD. As Veale et al. (2009) and other authors have noted, criteria for secondary depression include symptoms of depression developed after the onset of the OCD; patients report OCD as their primary problem; the expectation is expressed that feelings of depression would improve if the OCD were successfully treated. When comorbidity is confirmed, depressogenic thoughts, feelings of hopelessness and apathy, and other symptoms of depression should be concurrently addressed in treatment planning. Comorbid mood disorder generally requires pharmacotherapy combined with CBT, whereas this is often not the case for secondary depression. With respect to OCD related disorders, the highest comorbidity is found with tic disorders (17%) and with BDD (8–37%, Phillips, 2000). Patients with BDD report poorer insight and greater overvalued ideation, and they may be less responsive during cognitive therapy to consider alternate meaning of their obsessions and to resist rituals (Steketee & Neziroglu, 2003, see Radomsky, Ashbaugh, & Gelfand, 2007, for review). Tics, BDD, and OCD can be treated concurrently. Although rates across studies differ, anxiety disorders have been reported with OCD at the following frequencies: 12.8% comorbid anxiety disorders including social phobia (3.6%), panic disorder with agoraphobia (2.6%), and up to 20% generalized anxiety disorder (GAD) (Denys et al., 2004). As Purdon (2012) and others have pointed out, patients with panic disorder may be more risk aversive due to fear of having a panic attack during ERP. Those with social anxiety may be more reluctant to express thoughts

that provoke feelings of shame or to conduct ERP in front of a therapist or in natural environments. Patients with GAD may worry about the effect of ERP in exacerbating worry—"what if I worry all day long and can't stop?"—associated with higher rates of dropout and poorer outcome (Steketee, Henninger, & Pollard, 2000). Approximately 36% of OCD patients meet criteria for comorbid personality disorders (PD), for example, OCPD (9%) and dependent PD (7.6%), and these patients report lower functioning compared with OCD without PD (Denys et al., 2004). Some authors have found that comorbid PD had no impact on treatment, but other studies have reported poorer treatment response (e.g., Steketee, et al., 2001). Presence of personality disorders, particularly borderline personality disorder, may complicate the prognosis but can be treated concurrently. Importantly, some cases of apparent personality disorder may remit following treatment of severe Axis-I pathology. Evidence-based best practice is not to delay treatment of OCD because of these comorbidities. Importantly, successful treatment of OCD can often resolve related difficulties such as common secondary depression; however, the reverse is not the case. Presenting OCD is unlikely to resolve without specialty treatment and should be treated directly as soon as possible following initial presentation. A relatively small subset of patients with OCD suffer from a comorbid psychotic disorder (to be differentiated from poor insight and overvalued ideas) and this diagnosis requires pharmacotherapy. Patients with significant substance abuse (e.g., alcohol, street drugs) require concurrent or prior treatment for substance abuse that impedes sustained learning during CBT.

With respect to other psychological contributors, research has indicated an association between negative or stressful life events and symptom development (e.g., Jones & Menzies, 1998; Gothelf, Aharonovsky, Horesh, Carty, & Apter, 2004). For example, the risk of OCD has been found to be 10 times greater in persons with posttraumatic stress disorder (Sasson et al., 2005). Early life factors including perinatal difficulties, physical abuse, negative emotionality such as excessive criticism, poor motor development, and personality or conduct problems predict the incidence of OCD for some individuals (Grisham et al. 2011; Fineberg et al., 2013a). Specific normal but stressful life events such as birth of a first baby may also be associated with an increase of thoughts and

images with OCD themes such as fear of spreading contamination or causing harm or illness (Abramowitz, Khandker, Nelson, Deacon, & Rygwall, 2006). Intrusions that fluctuate during normal life development are hypothesized to reflect preexisting vulnerabilities if these develop into clinically significant obsessions (Rachman, 2003).

Chapter 3

Theoretical and Treatment Literature

Theoretical Literature

Behavioral models of OCD derive in part from Mowrer's two-stage model of fear and avoidance behaviors (Mowrer, 1939, 1960). In the first stage, which involves classical conditioning, neutral cues such as thoughts become associated with feared cues and then evolve into fear stimuli themselves. For example, recurrent thoughts about illness or disaster may occur following a serious major illness or a fire. More often repeated events through development may be contributors, such as emphasis by significant others on cleanliness, perfectionism, or the importance of controlling specific thoughts, fantasies, or behaviors (e.g., around religious, aggressive, or sexual themes). In Mowrer's second stage, which involves operant conditioning, fear is maintained through rituals, avoidance, or safety behaviors (e.g., Salkovskis, 1991). There is a great deal of evidence that supports the relationship between obsessions causing distress, and rituals and avoidance-reducing obsessional distress, adopted in etiological models of the disorder (APA, 2013).

Among the theoretical models important in the development of CBT strategies for OCD are those described by Salkovskis (1985, 1989), Salkovskis, Shafran, Rachman, & Freeston (1999), and Rachman (1997, 1998, 2003, 2006). For reviews of some of the theoretical models of OCD please see Taylor, Abramowitz, and McKay (2007). This pioneering work

focused initially particularly on the importance of patients' appraisals of intrusions related to responsibility; and has been invaluable in elucidating specific aspects of psychopathology in OCD that have been empirically examined. According to Rachman (1997): "people who are taught, or learn, that all their value-laden thoughts are of significance will be more prone to obsessions—as in particular types of religious beliefs and instructions" (p. 798). Rachman (1998) proposed that specific intrusions develop into obsessions only if they are considered personally significant and potentially harmful. He suggested that intrusions that are catastrophically misinterpreted as threatening are those "important in the patient's system of values" (p. 390), and that the essential problem in OCD is that people interpret their thoughts as signifying that they are bad, crazy, or dangerous (Rachman, 2003). The Obsessive Compulsive Cognitions Working Group (OCCWG, 1997, 2003, 2005) identified several domains of dysfunctional beliefs related to obsessions and rituals in addition to responsibility beliefs: overimportance and need to control intrusive thoughts, overestimation of threat, intolerance of uncertainty, and perfectionism. The work of the OCCWG culminated in the development of the two gold-standard measures of cognition in OCD, the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory.

Another focus of theory has examined metacognition, the information processing involved in monitoring, interpreting, and regulating the content and processes of cognition (Wells & Mathews, 1994; Wells, 2000). The excessive tendency of OCD patients to think about and to misappraise their own thoughts and cognitive processes has received considerable attention (e.g., Salkovskis, 1985; Purdon & Clark, 1999; Rachman, 2003). Research provides support for the importance of addressing "high-level" cognitive processes (Beck, 1996). For example, "cognitive self-consciousness" (a tendency to be aware of and monitor thinking) was found to be the only metacognitive dimension that differentiated OCD (more elevated in this group) from GAD patients (Cartwright-Hatton & Wells, 1997). A similar finding was reported after controlling for beliefs on the Interpretation of Intrusions Inventory and the Obsessional Beliefs Questionnaire (OCCWG, 2003; Janeck, Calamari, Riemann, & Heffelfinger, 2003). Gwilliam, Wells, and Cartwright-Hatton

(2004) found that metacognitive beliefs predicted OCD symptoms but beliefs about responsibility did not when their interrelationship was controlled. Solem et al., (2009) reported that change in metacognitions was a better predictor of posttreatment symptom levels compared with change in beliefs about responsibility and perfectionism. When the overlap between predictors was controlled for, only metacognition was significant. These findings are consistent with the validation study reported by the OCCWG (2003) that found OCD patients more strongly endorsed beliefs about overimportance and control of thoughts compared with patients with anxiety disorders and normal controls. That is, these commonly reported classes of beliefs are *specific* to OCD. Two studies have reported that change in overimportance/control of thoughts was a significant predictor of change in symptoms (Sookman, Dalfen, Annable, & Pinard, 2003; Adams, Riemann, Wetterneck, & Cisler, 2012). These findings suggest that patients' successfully learning alternative adaptive strategies for intrusive thoughts instead of overcontrol is associated with improvement in symptoms. Excessive responsibility has been found to be specific to OCD (OCCWG, 2003). However, a substantial group of OCD patients do not report elevated responsibility beliefs: for example, those with contamination fears not involving fear of harm to others, difficulty with symmetry, order or perfectionism, or discomfort that is disgust related (McKay, 2006; Olatunji, Wolitzky-Taylor, Willems, Lohr, & Armstrong, 2009). The relationship between patients' strategic processing of events (Beck & Clark, 1997) and dysfunctional beliefs will be discussed later in this volume.

There is strong theoretical support among leaders in the CBT field for consideration of schema-based CBT models in cross-diagnostic conceptualization and treatment planning (Beck, Emery, & Greenberg, 1985; Beck & Freeman, 1990; Beck, Freeman, & Davis, 2004; J. Beck, 2005; A.T. Beck, 1996; Beck & Haigh 2014).

> Cognitive schemas, defined as internally stored representations of stimuli, ideas, or experiences (Beck 1967), control information-processing systems (e.g., lower-order automatic processing versus higher-order reflective processing). When a schema is activated, corresponding meaning is derived from the belief and interacts with other cognitive, affective, motivational,

> and behavioral systems. Biased beliefs exist on a continuum ranging from adaptive to maladaptive and can be conditional or absolute. When the bias exceeds the built-in adaptive level, it increases the probability of an individual experiencing a subclinical or clinical disorder. (Beck & Haigh, 2014, p. 3)

The important concept of emotional schemas (Leahy, 2002, 2007, 2010; Leahy, Tirch, & Napolitano, 2011) pertains in theory and practice to individuals' experience and regulation of emotion as central to the development and maintenance of psychopathology. Thus, individuals who believe that their emotions are dangerous, out of control, or will persist indefinitely may be reluctant to engage in behavioral experiments or ERP. Pertinent to early childhood schemas, Salkovskis et al. (1999) proposed several pathways to the development of dysfunctional responsibility beliefs in OCD, including childhood experiences with excessive or too little responsibility, rigid rules for behavior, and incidents in which action or inaction contributed to misfortune to self or others. There is growing evidence of efficacy of schema-based approaches in treating depression (e.g., Malogiannis et al., 2014; Carter et al., 2013) and personality disorders (e.g., Bamelis, Evers, & Arntz, 2012; Dickhaut, & Arntz, 2014). Further research is required, particularly with treatment-resistant samples (Sookman & Pinard, 1999; Hawke & Provencher, 2011). Specialized schema-based interventions for OCD may be helpful as an augmenting strategy in combination with evidence-based CBT for patients who initially do not respond to optimally delivered CBT. The schema-based conceptual and treatment model developed by Sookman and colleagues is described and illustrated in Chapter 10.

Figure 3.1 shows the conceptual model developed by Sookman, Pinard, & Beauchemin (1994) to encompass evidence-based factors that maintain symptoms as well as their hypothetical interaction with core schemas (identity structure, elaborated in Chapter 10). Dysfunctional information processes include the well-recognized distortions of thought–action fusion ("If I think of a bad event, it is more likely to happen," Shafran, Thordarson, & Rachman, 1996) and emotional reasoning ("I feel scared, so I must be in danger," Arntz, Rauner, & van den Hout, 1995). Patients' cognitive responses to intrusions illustrated in the figure

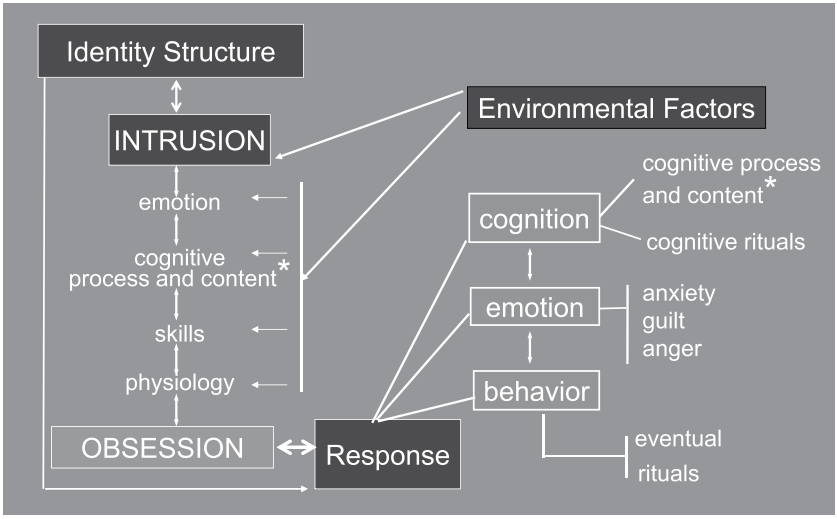

Figure 3.1. Transformation of an intrusion (adapted from Sookman, Pinard, & Beauchemin, 1994).

**Cognitive processes and content range from automatic thoughts to high-level information processing.*

range from appraisals and beliefs to more complex cognitive processes. The delineation "high-level information processing" refers to cognitive phenomena beyond automatic thoughts (Beck, 1996) and strategic processing of events (Beck & Clark, 1997). As described earlier, metacognition refers to the monitoring, interpreting, and regulating of processes and content of cognition (Wells & Mathews, 1994). Cognitive–emotional strategic processing includes appraisals of emotion, emotional responses to thoughts, and emotional responses to emotions (e.g., fear of fear, Goldstein & Chambless, 1978).

The Sookman et al. model was designed as a general, adaptable frame for individualized case conceptualization and treatment planning based on heterogeneity of symptoms and their function and meaning. The model is useful to discuss with patients during psycho-education, case conceptualization, treatment planning, and ongoing assessment of treatment response. Symptom maintaining factors are operationalized and targeted as precisely as possible for each case.

Treatment Outcome Literature

Scientist–practitioner intervention requires treatment recommendations and collaborative therapist–patient decisions based on individualized case conceptualization informed by the OCD treatment outcome literature. Specialized CBT for OCD comprises cognitive techniques to help patients to modify misinterpretations and to cope with feelings, and behavioral interventions to reduce OCD-maintaining behavioral responses to obsessions. Among the aims of CBT is to modify the personal meanings of thoughts from threatening to benign. After successful treatment, distressing obsessions should have declined and the associated avoidance and compulsive behaviors become absent (preferably) or insignificant. Clinicians working with OCD should be familiar with the indications for and application of the following evidence-based interventions: cognitive therapy and behavioral experiment protocols; imaginal exposure; complete in vivo ERP for cognitive and behavioral rituals; therapist-assisted ERP; ERP in naturalistic environments; specific interventions for symptom subtypes and related difficulties; indications for combined pharmacotherapy and CBT; and couple and family interventions (e.g., Salkovskis, 1985; Salkovskis, et al., 1999; Freeston et al., 1997; Wilhelm & Steketee, 2006; Rachman, 2003, 2006; Peris et al., 2008; Radomsky, Shafran, Coughtrey, & Rachman, 2010; Sookman & Steketee, 2010; Rachman et al., 2015). Decisions about session location, frequency, and intensity and involvement of family should be individualized and evidence based. The therapist should keep in mind predictors of response, such as adherence to homework (Simpson et al., 2010, 2011, 2012), and strategies to address these. The next section summarizes select treatment outcome results.

As discussed earlier, CBT that includes ERP is the empirically established psychotherapy of choice for OCD (APA, 2007; National Institute for Health and Clinical Excellence, 2005; March, Frances, Kahn, & Carpenter, 1997; Koran and Simpson, 2013). Available controlled research indicates that CBT combined with pharmacological treatment is no more effective than CBT alone for OCD symptoms (Foa et al., 2005; O'Connor et al., 2006; Rufer, Grothusen, Mab, Peter, & Hand, 2005; Romanelli, Wu, Gamba, Mojtabai, & Segal, 2014). Improvement is more

sustained with ERP compared with medication, and adding ERP to medication substantially improves the response rate (compared with adding a neuroleptic to an SSRI) and reduces susceptibility to relapse compared with medication alone (Kordan et al., 2005; Simpson, Franklin, Cheng, Foa, & Liebowitz, 2005; Simpson et al., 2008; Simpson et al., 2013). Indications for combined treatment include presence of severe comorbid mood disorder or other disorders or symptoms that require medication (e.g., Hohagen et al., 1998). The available literature also indicates that specific symptom subtypes require specific CBT interventions (for example, mental contamination; see Rachman, 2003; Rachman et al., 2015). A treatment protocol for patients with primarily obsessions only—previously considered more difficult to treat—consisting of specialized cognitive therapy and behavioral experiments, has theoretical support and demonstrated efficacy (Freeston, et al., 1997; Rachman, 2003; Whittal et al., 2010). Thus, it can be concluded from available empirical evidence that the first-line treatment of choice for OCD is subtype-specific CBT and that pharmacotherapy, where indicated, should be administered in combination with CBT for optimal and sustained results (Koran & Simpson, 2013).

Unfortunately, many individuals with OCD do not receive CBT (Goodwin, Koenen, Hellman, Guardino, & Struening, 2002; Stobie at al., 2007), and fewer still receive specialized CBT for OCD delivered or supervised by a therapist experienced with this disorder. Bloch et al. (2013) examined 10–20 year outcome of 83 OCD patients who had participated in a study on efficacy of SRI medications. Only 20% (17 of 83) of subjects had experienced a remission of their OCD symptoms at follow-up (Y-BOCS ≤ 8). Forty-nine percent of subjects were still experiencing clinically significant OCD symptoms. Response to initial SRI pharmacotherapy was significantly associated with long-term outcome. As the authors point out, it would be important to investigate whether response to an initial trial of optimal CBT similarly predicts long-term outcome.

Relatively few studies have examined long-term outcome and recovery rates following CBT alone or combined with pharmacotherapy. Importantly, results depend upon varying definitions of recovery. Simpson et al. (2006) analyzed their results comparing heterogeneous definitions of remission for three treatment groups. These authors reported that 7 of 19 (37%) patients who had received 3 months of ERP plus

Anafranil (ERP +CMI), and 7 of 21 (33%) patients who had received ERP alone (versus only 3 of 27 patients on Anafranil alone) met the most stringent criterion for recovery: Y-BOCS ≤ 7 at posttreatment. When remission was defined by Y-BOCS ≤ 12, 13 of 19 (68%) patients in the ERP + CMI group and 15 of 21 (71%) in the ERP group (compared with 8 of 27 or 30% in the CMI group) met these criteria. As these and other authors have pointed out, research treatment trials are generally time-limited (and manualized), and an optimal trial of CBT for OCD requires considerably longer than 3 months. Several studies have reported long-term maintenance of change following CBT (Freeston et al., 1997; Braga, Cordioli, Niederaurer, & Manfro, 2005; Cottraux et al., 2001; Vogel, Stiles, & Götestam, 2004; van Oppen, van Balkom, de Haan, & van Dyck, 2005; Whittal, Robichaud, Thordarson, & McLean 2008; Whittal et al., 2010). Van Oppen et al. (2005) reported the response of 71 randomized patients with an 87% retention rate at 5-year follow-up (cognitive therapy group Y-BOCS = 12.3, ERP group = 15.1). Remission was defined as reliable change and final Y-BOCS ≤ 12. In the cognitive therapy and ERP groups 53% and 40% of patients achieved remission respectively. Braga et al., 2005, defined recovery as Y-BOCS < 8 and a Clinic Global Impression (GCI) Score of 2 or less (range from 1 = minimal symptoms to 7 = very severe symptoms). At 12-month follow-up (FU), based on a sample of 42 patients 38% met criteria for recovery. Whittal et al. (2008) reported two-year FU for a sample of 41 treatment completers (69.5% retention). Y-BOCS scores for individual cognitive therapy or ERP of 10.3 and 11.2 respectively did not differ significantly at FU. Remission was defined as Y-BOCS ≤ 11 and minimal decline from pretreatment of 6 points. Sixty-one percent of patients who received individual treatment achieved remission at posttreatment with 51.2% maintaining their progress at FU. Fifty percent of patients reported continuing their medication at FU and 34% reported seeking additional psychological treatments during FU. Belloch, Cabedo, & Carrio (2008) examined the efficacy of 6 months of ERP compared with cognitive therapy with 29 OCD patients. This study included an initial intensive phase of in session therapist-assisted ERP. Using the posttreatment criteria of Y-BOCS ≤ 7 (and at least 6 points improvement), 8/13 (61.53%) in the ERP condition and 11/16 (68.75%) in the cognitive therapy condition were recovered at posttreatment. With the exception of one case in each treatment group, these

results were maintained at 1-year FU. In summary, the available research indicates that OCD is curable with improvement sustained in at least some cases. Sookman & Steketee (2010) and other authors have advocated that recovery be defined as no longer meeting criteria for OCD, with Y-BOCS ≤ 7 as well as other criteria that are outlined in Chapter 11 of this volume. In 2006 Rachman stated that, with some exceptions, for a period of 20 years "improvement rates are not improving" (p. 8, also cited by Whittal & Robichaud, 2012). It is a crucial challenge of OCD experts to examine the intervention and patient characteristics for those individuals who achieve recovery compared with those who do not, as well as mediators/mechanisms of change, in order to further refine treatment approaches and improve rates of outcome.

Studies on intensity, frequency, and location of ERP sessions have yielded variable results, based on methodological factors such as divergent samples, interventions, and outcome criteria. Franklin, Abramowitz, Kozak, Levitt, & Foa (2000) reported that 110 patients who received 15 sessions of CBT over 3 weeks showed mean Y-BOCS reductions of 60%, from 26.8 to 11.8, with a low dropout rate. This protocol was as effective at 3-months follow-up as twice-weekly therapy over 8 weeks (Abramowitz, Foa, & Franklin, 2003). This finding has important implications when reduction of symptoms is urgent and/or in response to geographic constraints. However, it would be important to identify those patients who require a greater number of spaced sessions in order to generalize gains. Neither regimen is sufficient for recovery in many cases. It has been reported that ERP administered only in the office is comparable with ERP in patients' naturalistic environments (Rowa, Antony, Summerfeldt, Purdon, Young, & Swinson, 2007). However, efficacy is likely related to the extent to which ERP to feared stimuli can be reproduced in the office as well as patients' capacity to adhere to ERP homework between sessions (Simpson et al., 2012). Further research is required to examine to what extent ERP effects in select clinical practice settings are comparable with clinical trials, reported often not to be the case (Stobie et al., 2007). Some studies found that individual CBT resulted in greater improvement than group treatment methods (e.g., Eddy et al., 2004); others reported that group ERP can be an effective format for select patients but that cognitive therapy is more effective when administered individually (McLean et al., 2001; Whittal et al., 2005).

Earlier research examined procedural variants related to outcome in ERP (for review see Abramowitz, 2006). Abramowitz (1996, 1997) reported that (a) therapist-assisted exposure resulted in more sustained efficacy compared with exposure performed as homework assignments by the patient alone; (b) ERP with complete response prevention (RP, completely stopping rituals) was more effective than incomplete RP; (c) frequency and duration of sessions and homework were related to outcome (prolonged 90-minute ERP sessions several times weekly, followed by frequent homework, resulted in greater symptom reduction); (d) combined imaginal and in vivo exposure was superior to in vivo exposure alone (Foa & Franklin, 2003); and (e) similar to rituals, reassurance seeking (e.g., checking questions) and safety behaviors (e.g., sanitizing wipes) during ERP may interfere with habituation (Abramowitz et al., 2003). Although self-directed exposure alone can be helpful in some cases (e.g., Fritzler, Hecker, & Losee, 1997), Tolin, Maltby, Diefenbach, Hannon, & Worhunsky (2004) also reported that patients receiving therapist-assisted ERP showed superior response in terms of OCD symptoms and functional impairment. Imaginal exposure may be helpful for some cases in facilitating preparatory coping prior to in vivo ERP (Foa & Franklin, 2003). Several authors (e.g., Foa et al., 2005) have advocated a graduated ERP paradigm that involves the most uncomfortable stimuli midway through treatment in order to create adequate repetitions and generalization. Graduated ERP is generally recommended initially over flooding (most feared stimuli) as more tolerable (Abramowitz et al., 2003), however, flooding may be preferable for some patients—for example where change is urgent, such as in care of children (e.g., Fontenelle et al., 2000). Case illustrations of flooding protocols are described in Chapter 7. Although complete response prevention is ideal whenever tolerable, and is the end goal, this may initially be too difficult for some individuals (Abramowitz et al., 2003). Therapist modeling of adaptive coping during exposures can enhance adherence and reappraisal (Steketee, 1993). When therapist-assisted ERP is administered, therapist fading is essential to optimize maintenance and generalization of gains. As several authors have pointed out (e.g., Gillihan, Williams, Malcoun, Yadin, and Foa, 2012) common "pitfalls" in ERP include not addressing the most distressing situations, leaving "pockets" of avoidance and

ritualization that render the individual susceptible to relapse, inappropriate decisions about indications for imaginal exposure combined with in vivo ERP, providing repeated reassurance, failure to identify and address the "core fear," failure to identify and effectively address cognitive rituals, insufficient recognition of the role of significant others and their inclusion in treatment and, very importantly, insufficient training or preparedness on the part of the therapist to therapeutically handle their patients' (and their own) anxiety.

Several studies have demonstrated the efficacy of both ERP and cognitive therapy in reducing symptoms and dysfunctional beliefs (e.g., Cottraux et al., 2001; Emmelkamp, van Oppen, & van Balkom, 2002; McLean et al., 2001; Whittal et al., 2008, 2010). Cognitive therapy developed for obsessions (Freeston et al., 1997; Rachman, 2003) involves helping the patient to identify and modify appraisals, emotional responses, and information processing (e.g., hypervigilance, selective attention) in response to intrusions perceived as threatening. Methodological factors such as overlap of therapeutic ingredients, targets and amount of cognitive therapy administered, and limited sample size contribute to difficulty in assessing to what extent cognitive therapy significantly adds to the efficacy of ERP (Vogel, Stiles, & Götestam, 2004; Abramowitz, 2006). Nonetheless, there is considerable support for combining cognitive therapy with ERP for OCD. Dropout rates have been reported to be lower in CBT that includes cognitive interventions (Foa et al., 2005). Individuals with OCD report varied emotional responses, and complex metacognitive dysfunction, that may be difficult to ameliorate with exposure alone (Foa & McNally, 1996; Wilhelm & Steketee, 2006). Fisher and Wells (2005) reported that explicitly challenging beliefs about the threatening meaning of intrusions with behavioral experiments was more effective in reducing dysfunctional beliefs, urges to ritualize, and anxiety compared with ERP administered with a habituation ("getting used to anxiety") rationale. As noted by Craske et al. (2008, 2014) the formation and retrieval of new non-threat associations (known as inhibitory learning) rather than habituation may be a more important determinant of corrective learning during effective exposure. Further research is needed to clarify how to optimize behavioral experiments and/or ERP and to examine mediators of improvement. The recommended practice by most OCD

experts is combined cognitive therapy and behavioral interventions as the first-line treatment. As Rachman states (2006):

> In difficult cases the initial use of cognitive therapy can modify the maladaptive beliefs and cognitions sufficiently to smooth the way for behavioral experiments and cognitively structure ERP exercises, not only modify the unadaptive cognitions but also have a way of unearthing previously unidentified cognitions. When the cognitive therapy begins to reduce the fear of contamination it becomes a little easier to introduce the ERP exercises which were formerly blocked by the presence of overriding fear. Behavioral experiments are a valuable tactic for gaining new information about the fear while simultaneously engineering successive disconfirmations of over-predicted fear/ patients with an overriding fear of contamination are better able to approach and then touch a contaminant if the task is presented as a limited behavioral experiment designed to collect information rather than as a direct exercise that commits them to touching a lengthy list of very disturbing contaminants. If and when the patient's maladaptive beliefs and misinterpretations are substantially reduced, the ERP exercises can proceed at a good pace, and the fear and avoidance decline accordingly. In the absence of a clear cognitive analysis, progress in ERP can be slow. (pp. 161–162)

Despite the above excellent studies, based on available research to date, approximately 50% of patients do not respond optimally to CBT even when combined with pharmacotherapy. This includes patients who refuse to participate or drop out of ERP (20%), do not improve (25%), or have relapsed at follow-up (Baer & Minichiello, 1998; Cottraux, Bouvard, & Milliery, 2005; Foa et al., 2005; Whittal, Thordarson, & McLean, 2005; Daflos & Whittal, 2012). In the relatively few studies where this is reported, with a few exceptions, only one-quarter of samples recover completely (e.g., Eddy, Dutra, Bradley, & Westen, 2004; Bloch et al., 2013). This is in part due to many patients being unwilling or unable to collaborate fully with ERP (Araujo, Ito, & Marks, 1996; Whittal et al., 2005; Simpson et al., 2013; Bloch et al., 2013) and to other patient characteristics, but importantly also to the process and content of CBT administered. In a longitudinal investigation of efficacy of CBT for OCD, being

too anxious or fearful to participate was endorsed as a reason for not initiating treatment or dropping out prematurely by 31% and 29% of participants respectively (Mancebo, Eisen, Sibrava, Dyck, & Rasmussen, 2011). Fear of engaging in CBT was the *main* reason for not initiating treatment or dropping out for 20% and 21% of participants respectively. Although data were not available on specific fear provoking aspects of CBT, this study highlights the importance of fear associated with specific CBT techniques, such as ERP, as an important barrier to treatment initiation and completion.

Residual symptoms that confer susceptibility to symptom exacerbation and chronic OCD, even at subclinical levels, are commonly associated with long-term psychosocial impairment and secondary depression. It is therefore important to maximize improvement in symptoms and related difficulties. Given that our aim is recovery at posttreatment, and long-term maintenance of improvement, for as many patients as possible we remain far from our goal for many patients (Sookman & Steketee, 2010). An important advance by experts in this field is the development of specialized approaches for symptom subtypes that are discussed in Chapters 6 to 9 (for additional discussion of these approaches, see Rachman, 2003, 2007; Sookman, Abramowitz, Calamari, Wilhelm, & McKay, 2005; Antony, Purdon, & Summerfeldt, 2007; Abramowitz, McKay, & Taylor, 2008; Radomsky et al., 2010; Rachman et al., 2015; Levy and Radomsky, 2014). At present, there remains a lag between development of these innovative approaches and methodologically adequate controlled outcome studies to examine their efficacy.

"Third wave" CBT is characterized by emphasis on mindfulness and "acceptance" of inner experience, skills that improve observing and accepting inner experience, and change in behavior consistent with the person's values or objectives (e.g., see Hayes, Follette, & Linehan, 2004). Promising approaches have been reported; however, these require further examination with OCD and will not be elaborated in this volume. In assessing the efficacy of these approaches, an important issue is overlap of therapeutic ingredients, as CBT incorporates at least some of these interventions. Comparison of third wave interventions with "treatment" conditions such as relaxation (demonstrated to be ineffective for OCD) does not answer the question of whether these interventions add significantly to the efficacy of optimally delivered evidence-based CBT.

Predictors of Outcome—Patient Characteristics

A review of studies on patient characteristics that impact outcome indicates mixed results. In summary, it appears that duration, severity, or subtype of OCD symptoms and/or comorbid disorders such as comorbid major depression or anxiety disorders do not reliably predict outcome. That is, patients with longer duration of illness, greater symptom severity at pretreatment, or comorbidity will not necessarily respond less well. These questions have been examined with different samples, methodologies, and results (e.g., Foa, Abramowitz, Franklin, & Kozak, 1999; Steketee et al., 2000; Steketee, Chambless, & Tran, 2001; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002; Braga, Cordioli, Niederauer, & Manfro, 2005; Himle, Van Etten, Janeck, & Fischer, 2006; Hansen, Vogel, Stiles, & Götestam, 2007; Diniz et al., 2011; Belotto-Silva et al., 2012; Eisen, Sibrava, Boisseau, Mancebo, Stout, Pinto, & Rasmussen 2013). As Whittal & Robichaud (2012) have noted in examining some of these studies, the deleterious impact of comorbid depression in predicting poorer response to behavior therapy has been reported to be reduced or eliminated when cognitive therapy is administered. Importantly, evidence-based guidelines for treatment of OCD require careful assessment and appropriate treatment of comorbid disorders (Koran & Simpson, 2013).

It is well recognized that CBT treatment outcome studies have underrepresented several symptom subtypes. Ball, Baer, and Otto (1996) found that patients with mixed rituals or those related to symmetry, exactness, ordering, repeating, counting, or slowness were underrepresented, comprising 12% of samples studied, relative to their approximate prevalence (Calamari et al., 2004). Rates of improvement reported from approaches developed for checking and washing (75% of samples) do not necessarily generalize to these subgroups on which further research is required.

Poor insight occurs to varying degrees in 14–31% of persons with OCD and has reliably been associated with worse treatment outcomes (Veale, 2007; Jacob, Larson, & Storch, 2014). The term *insight* refers to "the degree to which the sufferer is aware of the irrationality of their symptoms" (Steketee & Neziroglu, 2003, p. 179). Those individuals with poor insight are extremely certain that the feared consequences of their

obsessions are reasonable and warrant the time spent on compulsions, avoidance, etc. As Veale (2007) has observed, the term *insight* is often used synonymously with *overvalued ideation*. At one end of the continuum is the recognition that the obsessional idea is irrational; at the other, the person holds a delusional belief that it is fully rational. When the latter is the case, the person can be specified as having OCD "with poor insight" (APA, 2013). Poor insight is associated with earlier age of onset, longer duration of illness, greater symptom severity, higher comorbidity, and poorer response to pharmacotherapy (Kishore, Samar, Reddy, Chandrasekhar, & Thennarasu, 2004). Matsunaga et al. (2002) found that OCD sufferers with poor insight had the same degree of functional impairment as OCD sufferers with comorbid schizophrenia. In summary, degree of insight has important implications for illness onset, course, and response to treatment.

A robust research base, particularly well researched with pediatric OCD but also applicable to adults, indicates that accommodation by family or significant others to OCD symptoms (e.g., participating in rituals, providing repeated reassurance) interferes with treatment efficacy (Calvocoressi et al., 1995; Storch et al., 2010; Peris & Piacentini, 2013; Boeding et al., 2013; Thompson-Hollands, Edson, Tompson, & Comer, 2014). Accommodation to symptoms and expressed family hostility has been associated with a greater rate of dropout and poorer response among treatment completers (Chambless & Steketee, 1999). Patients who reported feeling more upset by relatives' criticism reported greater discomfort during exposure and higher daily ratings of anxiety and depression (Steketee, Lam, Chambless, Rodebaugh, & McCullouch, 2007). Severity of OCD symptoms is associated with higher levels of family accommodation (Gomes et al., 2014). These findings underline the importance of including family members or significant others during CBT for OCD unless contraindicated. Please see further discussion in Chapter 5.

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Chapter 4

"Resistance" to Specialized Cognitive Behavior Therapy for OCD

This chapter summarizes some overlapping reasons for resistance that are commonly reported by patients who have difficulty benefiting from cognitive therapy and participating in ERP. Suboptimal response may be due to inadequate application of evidence-based interventions, use of manualized protocols in treatment research trials that do not permit individualized CBT delivery or adequate treatment duration, and patient characteristics that impact treatment. As several authors have pointed out (e.g., Sookman & Pinard, 1999; Leahy, 2003), there are different reasons for and meanings of resistance, such as fear of distress or uncertainty, skills deficits, overvalued ideas, motivational issues, and response to family hostility. Criteria are needed to further define resistance to CBT, to identify contributing factors, and to design optimal strategies for these (e.g., Cottraux, Bouvard, & Milliery, 2005). As several experts have recommended (e.g., Stewart, Stack, Farell, Pauls, & Jenike, 2005), an OCD patient is not necessarily CBT resistant because he/she has failed to respond to outpatient CBT trials with or without pharmacotherapy.

A patient should not be considered CBT resistant if optimal CBT, defined by available evidence-based expert guidelines, has not been delivered or attempted. As discussed in Chapter 1, a crucial distinction should be made between "technical" treatment failures when an individual does

not improve due to the inadequacy of treatment and "serious" treatment failures where an individual does not respond to adequately delivered treatment (Rachman, 1983). In my experience, also reported by other OCD experts (e.g., Fineberg et al., 2013a, 2013b, 2013c), the majority of persons with OCD who present as being "treatment-resistant" or refractory fall into the technical treatment failure category, having received inadequate CBT. Examples of common inadequacies are inaccurate psycho-education; insufficient or incorrectly applied ERP, including restricted to the office; partial ERP; sessions of inadequate duration and/or frequency (e.g., time-restricted); premature termination of treatment; failure to deliver treatment that is specific to subtype characteristics or at a developmentally appropriate level; and failure to include significant others as appropriate. A major additional difficulty addressed in this chapter is oversimplified conceptualization of reasons for and meanings of difficulties that patients experience in collaborating fully during treatment. Among the most common simplifications is "the patient is not motivated to change." Inaccurate conceptualization of resistance is inevitably associated with inaccurate intervention to overcome resistance. The next section outlines outcome literature relevant to treatment resistance, followed by elaboration of common reasons for resistance to treatment in OCD, adapted from Sookman and Steketee, 2010 (p. 6). Subsequent chapters illustrate interventions that address these issues.

Outcome Literature Relevant to Treatment Resistance

Relatively few approaches have been developed for resistant OCD and, as discussed in Chapter 1, consensus on a definition for CBT resistance in OCD does not currently exist. Most reports involve case series with heterogeneous previous treatment trials, or examination of inpatient residential treatment.

Sookman and Pinard (1999) reported a case series of seven patients who had not responded to an average of 2 years prior CBT that had included ERP combined with pharmacotherapy (two patients had refused medication). Prior treatment was reported by patients and documented by previous therapists. Treatment involved an average of 9 months of CBT (cognitive therapy, behavioral experiments, and ERP)

combined with schema-based interventions originally developed specifically for OCD by Sookman, Pinard, and Beauchemin (1994). Six of the seven patients responded with improvement on the Y-BOCS from moderately severe to recovered as defined by Y-BOCS ≤ 7. One case was mildly ill at posttreatment (Y-BOCS = 11) but following several additional booster sessions was further improved at follow-up. At 9-month to 2-year follow-up five of the patients had sustained their improvement. Two patients who were severely ill at pretreatment reported a change from recovered to mild illness at long-term follow-up (Y-BOCS had improved from 30 to 2 and from 24 to 5 after treatment, but had drifted back up to 9 and 12 at follow-up of 1 and 2 years respectively). These patients lived further away from the hospital and had declined booster sessions (which highlights their importance). In this small sample, substantial change in dysfunctional beliefs was also maintained at follow-up, in some cases resolved to within normal limits. This approach is discussed and illustrated in Chapter 10 of this volume with summary of more recent outcome data with a larger sample.

Krochmalik, Jones, and Menzies (2001) reported a case series of five adult outpatients with washing rituals who were nonresponsive to two previous courses of ERP and SSRIs. In response to a brief course of Danger Ideation Reduction Therapy (which incorporated cognitive techniques but not ERP), four of five patients were classified as recovered based on self-report of OCD symptoms. Rosqvist, Thomas, & Egan, 2002, reported the administration of home-based CBT and ERP for four adult outpatients with a history of unsuccessful trials of behavior therapy, cognitive therapy, and pharmacotherapy. Three of the four patients responded, with a mean reduction of 49% on Y-BOCS. Maltby & Tolin, 2005, examined a brief readiness intervention (incorporating motivational interviewing) versus waitlist, followed by CBT. Three of seven individuals in the readiness intervention group completed CBT, with a mean reduction of 59% on Y-BOCS, however the dropout rate from ERP was high (50%).

Van Dyke and Pollard (2005) and Pollard (2007) also underlined inadequacies of administration of CBT as central to "treatment resistance." In their "St. Louis model" these authors operationalize and focus on a set of patient-related factors they labeled as "treatment-interfering behaviors" (TIBs). TIBs are assessed during interview and on their

Treatment-Interfering Behavior Checklist (Van Dyke & Pollard, 2005), defined as: "any behavior the therapist believes is incompatible with effective participation in therapy or the pursuit of recovery" (Pollard, 2007). Their "readiness therapy" addresses dysfunctional beliefs, skills deficits, emotional dysregulation, and incentive/motivation issues that may interfere with collaboration in ERP. Their approach involves intensive outpatient CBT for 2 hours daily, including therapist-assisted ERP and two or three additional individual sessions weekly for other interventions (e.g., cognitive restructuring, pharmacotherapy). Gradual fading of therapist involvement and relapse prevention are additional components. Meetings with family members are offered for some cases. In a preliminary report, readiness treatment successfully reduced TIBs in 7 of 11 treatment-resistant OCD patients (Van Dyke & Pollard, 2005). Further examination of this approach has not been yet been carried out.

Rachman et al., 2015, reported the results of a case series of 12 OCD patients diagnosed with mental contamination. Nine patients had received prior CBT including ERP, and four had received prior pharmacotherapy, without significant effect. Pretreatment Y-BOCS scores indicated moderately severe to severe OCD. Treatment consisted of a specialized treatment protocol for mental contamination for a duration of 10 to 20 sessions of 50 minutes each. Interventions included psycho-education with corrective information; specific focus on current individualized perceived threat; "imagery rescripting" (p. 113); identification, reappraisal, and modification of cognitive biases and emotional experiences; "contrasting explanations" (p. 111), that is, toward more benign and realistic reappraisals; and behavioral experiments. At posttreatment 7 of 12 patients no longer met diagnostic criteria for OCD (Y-BOCS < 7) and these gains were maintained at 6-month follow-up. Those patients who were able to collaborate in cognitive analyses and "contrasting comparisons" (Explanation A versus Explanation B), with behavioral experiments, showed the greatest improvement. The authors noted that patients with long-standing mental contamination would likely require longer durations of treatment, combined with interventions to address comorbidity if present (e.g., comorbid mood disorder).

The efficacy of inpatient residential treatment has been examined by several investigators (Osgood-Hynes, Riemann, & Björgvinsson; 2003;

Stewart, Stack, Farrell, Pauls, & Jenike, 2005; Brennan et al., 2014). Stewart et al., 2005, reported the efficacy of inpatient residential treatment (IRT) for a sample of 403 patients with severe OCD who had not responded to outpatient treatments. Intensive CBT was administered for 2 to 4 hours daily and combined with pharmacotherapy. Length of hospitalization averaged 66 days, indicating approximately 200 hours of therapy. Mean Y-BOCS score for these severely ill patients was reduced from 26.6 to 18.6. An important recommendation made by these authors is that up to 3 months of IRT should be administered before considering an OCD patient treatment refractory. Osgood-Hynes, Riemann, and Björgvinsson (2003) reported that following an average duration of 46 to 65 days of IRTs at two different sites, mean Y-BOCS scores for their inpatients reduced by approximately half (47–55%). Brennan et al. (2014) reported that following 3 months of IRT that included ERP and pharmacotherapy, 53 of 281 patients examined achieved "wellness" defined as Y-BOCS ≤ 12. These results indicate that intensive inpatient CBT can be an effective strategy for some patients whose symptoms have not responded to an optimal trial of outpatient therapy. We would expect this to be the case for patients whose rituals do not take place exclusively in their home. Intensive therapist-assisted CBT should be administered in patients' naturalistic environments if possible prior to consideration of IRT, and should follow discharge to optimize continued progress.

Reasons for and Meanings of Resistance to Evidence-based CBT for OCD[1]

1. The patient is reluctant to disclose content of some obsessions (Rachman, 2007) because of fear of being judged or perceived as crazy or dangerous. For example: "If I tell the therapist I have thoughts of molesting children, running over bodies, suffocating my baby sister, poisoning my dog, forging checks, yelling obscenities in Sunday school, etc., the therapist might think I am a child molester (or other awful label) and that I might actually do it one day. Maybe it would have to be reported, I will be locked up, and my life will be ruined."
2. The patient's model of therapy and process of change includes the belief that talking can sufficiently change thoughts and feelings to

the extent that facing feared events without ritualizing would not provoke strong distressing feelings. If this is possible, why face emotional pain perceived as highly distressing or intolerable?

3. The patient fears that intrusions, images, or other experience such as sense of incompleteness or feeling "not just right" will worsen or persist if rituals are not performed. The patient fears that symptoms will interfere with basic functioning or that these will be experienced as intolerably distressing.
4. The patient fears experiencing, or is unwilling to experience, strong feelings of fear, anxiety, and other emotions (e.g., guilt, disgust, incompleteness) that ERP or behavioral experiments would provoke, with resultant persistence of risk aversion. These responses may persist despite provision of emotion-management strategies, offer of therapist-assisted ERP, education about the essential role of facing feelings and the high probability distress will subside faster than anticipated, and cognitive therapy for dysfunctional beliefs associated with distress. For example: "Strong feelings are dangerous and will never go down. I could go crazy."
5. A strong discrepancy persists between beliefs experienced on "quiet reflection" or reported on cognitive scales and beliefs experienced during exposure to feared situations that interfere with full collaboration during ERP or behavioral experiments. For example: "I don't believe it's true, but I feel it's true" (Sookman & Pinard, 1999).
6. The patient has poor insight or overvalued ideas that are intransigent to disconfirmation in cognitive therapy and behavioral interventions. These beliefs are strongly endorsed even when the individual is not in distress and removed from feared situations. In these cases, there is little discrepancy between cognitive and emotional aspects of belief.
7. The patient feels unwilling, or unable, to accept the perceived risks of not engaging in rituals or other safety behaviors (e.g., complete loss of control, irreversible spread of contamination, fatal illness, preventable harm to others, future calamity, eternal damnation). The patient may agree to ritual abbreviation, restriction, or response delay (Schwartz, 1996) but refuse complete ERP.
8. The patient has perceived and/or actual skills deficits with respect to inner and external events. Examples are difficulties with emotional

tolerance and regulation; dysfunctional appraisals of intrusive thoughts as well as emotional experience; problem solving, decision making, interpersonal, and stress management skills deficits. Rituals have become a central cognitive and emotion-relieving strategy with few, if any, perceived alternatives.

9. The patient goes through the motions of engaging partially in cognitive therapy and ERP or behavioral experiments without substantial change in emotional responses, dysfunctional beliefs, or strategic processing of internal and external events.
10. The patient is unable to tolerate reduction in therapist time and/or treatment gains fail to generalize to other non-treatment settings. That is, there is difficulty with therapist fading and generalization of treatment gains.
11. Intra-familial and interpersonal problems interfere with treatment (e.g., accommodation to symptoms by significant others, family conflict).
12. Dysfunctional appraisals and strategic processing, urges to ritualize, and ritualization recur following discontinuation of therapy.
13. The therapist hypothesizes that core schemas may be interfering with emotionally meaningful accommodation to new experience (Piaget, 1960).

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Chapter 5

The Scientist–Practitioner Model

This chapter summarizes evidence-based assessment and treatment protocols for OCD and outlines the knowledge base and clinical competencies required by clinicians working with OCD.

OCD Assessment Protocol

Content of Assessment

Specialty assessment for OCD should be developmentally adapted, multidimensional, and include the following elements with appropriate consent: self-report of subjective experience including intrusive thoughts, related appraisals and beliefs, urges to ritualize; distress, fear, and other symptom-related experience; cognitive and behavioral rituals, triggers of symptoms, feared consequences, attempts to resist, daily frequency and duration of symptoms; perceived meaning of symptoms and impact on self-percept; degree of insight; interference in normal activities and psychosocial functioning in multiple spheres (intra-familial, school/work, peers); medical status and medication; capacity for autonomous self-care; comorbidity (e.g., depression and suicidality, substance use, tics); normal developmental milestones and difficulties; reports and behavioral observation on similar dimensions as appropriate by family or significant others, primary care professionals; previous assessment and treatment history (e.g., GPs, mental health professionals); and self-report by the patient on standardized measures of symptoms and

measures of psychosocial functioning, degree of impairment, and quality of life (select measures are listed in this chapter). Assessment in some cases requires home visits for behavioral observation of rituals and other symptoms. Assessment of treatment response should also be multidimensional, including adherence and progress during therapist-assisted in vivo exposure and homework assignments, experiential behavioral experiments, progress reports of significant others (with consent), therapist–patient relationship, psychometric dependent measures, idiographic record keeping for some cases, and change on neurobiological indices for select cases.

The clinician should be familiar with interview assessment of OCD and related symptoms; the relation among intrusive thoughts, dysfunctional appraisals and beliefs, distressing experiences, cognitive and behavioral rituals, avoidance, and safety behaviors; assessment of comorbidity; clinician rated and self-report standardized measures of symptoms, related difficulties (e.g., characteristic beliefs), anxiety, depression, psychosocial functioning, and quality of life; assessment with family members (with patient consent); and behavioral observation strategies. The clinician should be familiar with varied subtype expressions including the unusual or "bizarre," that even with limited insight do not preclude a diagnosis of OCD. As Veale, Freeston, Krebs, Heyman, and Salkovskis, 2009, note:

> In young people, there may be a greater risk that OCD is wrongly diagnosed as a psychotic illness, especially if they present with unusual obsessions, which are mistaken for delusions. Sometimes the distress caused by bizarre and frightening obsessions leads to fear-driven behaviours, which are interpreted as behavioural manifestations of psychosis, such as shouting out loud in an attempt to cancel out thoughts. In one series of young people presenting with unusual obsessions about magically acquiring unwanted characteristics from others (termed "transformation obsessions"), the majority had previously received an incorrect diagnosis of psychosis and had often been prescribed unnecessary antipsychotic medication. (Volz & Heyman, 2007, pg. 770)

This also applies to OCD through the life span, making it clear that the high incidence of comorbidity requires broad-spectrum diagnostic acumen.

The clinician should be familiar with administration and scoring of standardized measures of symptoms and related difficulties. Some measures should be administered to all patients (e.g., Y-BOCS, measure of treatment adherence) while others are useful to consider following clinical interview based on presenting symptoms (e.g., Mental Contamination Scale). Appropriate and useful measures include but are not limited to the following: Y-BOCS (Goodman et al., 1989; Scahill et al., 1997); Beck Depression Inventory (Beck, Steer, & Brown, 1996); Clinical Global Impressions-Improvement (CGI-I; Guy, 1976); Obsessive Beliefs Questionnaire-87 and Interpretation of Intrusions Inventory (OBQ-87, III, OCCWG, 2001, 2003, 2005;[1] Vulnerability Schemata Scale (Sookman, Pinard, & Beck, 2001); Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998); the USP-SPS (Rosario et al., 2009, which evaluates the presence and severity of sensory perceptions associated with rituals including physical sensations, "just right" perceptions triggered by tactile, auditory, or visual sensations, and feelings of incompleteness, energy release or general sense of inner tension or energy associated with need to release by action, and "urge only" perception); Personal Significance Scale (PSS; Rachman, 2003); Thought–Action Fusion Scale (Shafran, Thordarson, & Rachman, 1996); Thought Fusion Instrument (Wells, Gwilliam, & Cartwright-Hatton, 2001); Overvalued Ideas Scale (OVIS; Neziroglu, McKay, Yaryura-Tobias, Stevens, & Todaro, 1999); Mental Contamination Scale (TAF-MC: Rachman, 2006); Sensitivity to Contamination Scale (S-CTN; Rachman, 2006); Not Just Right Experience Questionnaire–Revised (Coles, Frost, Heimberg, & Rheaume, 2003); Homework Compliance Form (Promakoff, Epstein, & Covi, 1986); Patient EX/RP Adherence Scale (PEAS; Simpson et al., 2010); Family Accommodation Scale (Calvocoressi et al., 1995); and Family Accommodation Scale–Partner Report (FAS-PR; Peris et al., 2008). Assessment of comorbid personality disorders may be assessed on the Millon Clinical Multiaxial Inventory–third edition (MCMI—III; Millon, Millon, & Davis, 1997).

It is important to assess quality of life and global functioning as well as symptoms on standardized measures before and following treatment. Symptoms, beliefs, and feelings are also assessed ideographically in some cases.

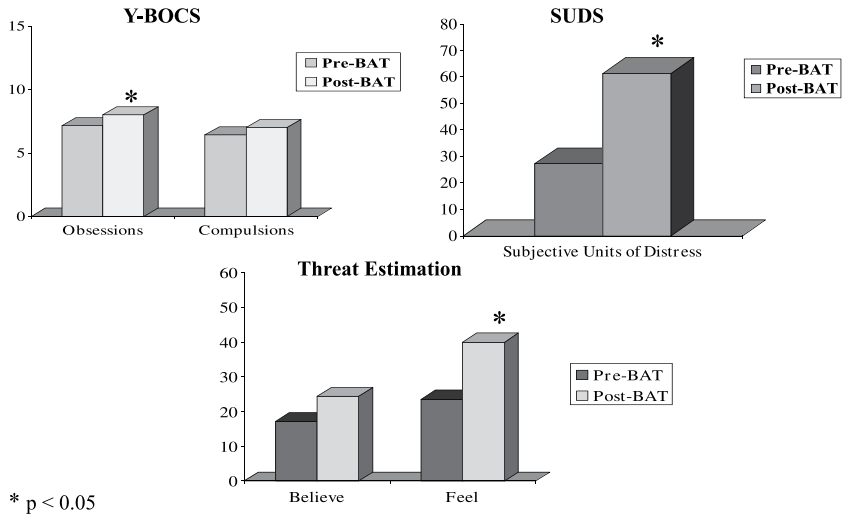

Figure 5.1. Behavioral Avoidance Test (Steketee et al., 1996) CBT (N = 7)

A particularly important therapist observational methodology is the Behavioral Avoidance Test (BAT; Steketee, Chambless, Tran, Worden, & Gillis, 1996). Figure 5.1 shows the results of individualized BATs carried out in the home of seven patients at approximately the mid-treatment point in our OCD Clinic. This methodology facilitates assessment and modification of information processing, emotional response, rituals, and avoidance that occur in feared situations. The therapist and patient compile a list of feared stimuli, avoidances, and select situations and objects that are graded by level of severity, distress, interference, and relevance to symptoms: for example, sharp objects, appliances, objects perceived as contaminated, etc. During BAT the patient is asked to approach feared objects or situations as closely as possible and to rate his/her anxiety using a simple measure of anxiety such as a subjective units of distress (SUDS) scale of 0 (calm or no anxiety) to 100 (extremely anxious). The therapist observes the degree and extent of the person's avoidance of each specific object or situation. In our clinic, patients are asked to rate on a 0 to 100 scale how much *they believe the threat-related idea is true and how much they feel the idea is true* (cognitive and emotional aspect of belief, Sookman & Pinard, 1999). The results shown for these patients illustrate that, as expected, ratings of intrusive thoughts and distress increased

following exposure to feared stimuli. Of special interest, patients who were in mid-treatment did not rate an increase in their belief about threat despite BAT provocation, however, the emotional aspect of their belief increased significantly in response to provocation. These findings suggest that the extent to which patients *feel their threat-related idea is true* during feared situations (this variable is not equivalent to anxiety) could be an important outcome measure and that, further, for some patients, response on self-report measures of belief may not accurately reflect their perceptions during in vivo situations.

Process of Assessment

From initial contact communications are developmentally adapted, collaborative, respectful, "down to earth," normalizing, empathic, underline strengths and resources, and address impact on self-perceptions ("It's my fault, having OCD and getting help means I'm stupid or weak. I'm not like other people; I'm going crazy. I'm not a person. I'm just OCD"). As a result of the intense suffering involved, most individuals express eagerness for specific treatment for OCD. Many report a history of help seeking. Some individuals may attend unwillingly with parents or significant others because of reported negative experiences with previous treatment attempts or for other reasons. Coercion is never used, but education and encouragement are helpful. When patients become aware of specific strategies they could learn and apply to "take charge and beat OCD," most wish to participate.

The Therapeutic Relationship

Therapeutic development and management of the patient–therapist relationship is integral to CBT and is discussed in several case illustrations throughout this volume (please see Gilbert & Leahy, 2007, for discussion and illustration of the therapeutic relationship during general CBT). Development of a collaborative therapeutic alliance is fostered from initial contact on. Specific evidence-based treatment interventions are required for improvement and recovery; at the same time these are combined from initial contact with "non-specific" factors such as a culturally

sensitive empathic and collaborative process, speaking in the developmentally adapted "language" of each person, and active depathologizing the impact on self-esteem.

The CBT model is based on respect for the "informed consumer" in a collaborative framework. Informed consent is an essential process that protects the ethical rights of those who undergo health care and forms the basis for a therapeutic relationship. Therapies that emphasize the self-efficacy of the patient have been found to have better outcomes compared with therapies that do not (Beahrs & Gutheil, 2001; Pope & Vasquez, 2007). Patients are informed in detail about the procedures, involvement of third parties, and the limits of confidentiality. Ethics dictate that clinicians ensure that participation is voluntary and does not involve coercion (Sookman, 2015). This process establishes the therapist and patient as partners working toward common objectives. Evidence-based interventions that are recommended are clearly described. However, the patient is informed that individualized treatment steps are developed in collaboration with the patient (APA, 2002, Principle C). Detailed descriptions are provided in advance about each new in vivo or imaginal exposure exercise by the therapist, which must be agreed to by the patient before it is initiated (e.g., Abramowitz, 2006). To promote collaboration the therapist should present a clear rationale for recommended interventions and a detailed explanation of their steps. Informed consent for a specific behavioral experiment or exposure step may be discussed during a planning session in the office and subsequently in the in vivo environment. Patients may change their mind and withdraw their consent during in vivo sessions, for example, due to initial intolerance of distress. Similarly, there is ongoing discussion of conceptualization, objectives, and processes of cognitive therapy that evolve collaboratively during treatment. A fundamental aspect of an effective relationship in administering CBT for OCD is preparedness on the part of the therapist to therapeutically handle the distress that will inevitably occur. This should include the capacity to model adaptive responses (cognitive, emotional, behavioral, interpersonal) during "hot" moments that occur during varied interventions. Many OCD patients require collaborative therapist-assisted behavioral interventions in their home or other environments outside the office

combined with the practice of cognitive therapy strategies, as well as inclusion of significant others commensurate with progress in therapy. Thus, the therapist requires sufficient supervised experience with heterogeneous clinical skills that match the heterogeneity and treatment requirements of this disorder.

Treatment Phases and Components

Psycho-education

Psycho-education to the patient (and family and collaborating care providers, with patient consent) includes the following: discussion of commonly experienced difficulties during normal development; prevalence and precipitants of OCD (e.g., normal developmental stressors); role of appraisals of intrusions, response to distress, cognitive and behavioral rituals, and avoidance in perpetuating symptoms; the fact that many studies show that persons without OCD experience the same content of intrusions but do not attribute dangerous meanings to these (see Figures 5.2 to 5.4).

Specific evidence-based strategies to help the individual to reduce distress and symptoms and *to promote self-efficacy* are described. Models of adaptive family involvement are introduced. As described earlier, development of a collaborative therapeutic alliance with the person is fostered.

- Thought of an accident happening to husband
- Thought of acts of violence during sex
- Thought that something is wrong with health
- Thought that chances of my having an air crash are less if a relative had one
- Thought that my family will be harmed by asbestos particles in the house

Figure 5.2. Intrusive thoughts in a non-clinical sample.
Source: Rachman & de Silva, 1978

- Imagining someone close to me hurt
- Imagining doing something dramatic like robbing a bank
- Remembering being embarrassed and humiliated
- Imagining sexual acts with known and unknown women

Figure 5.3. Intrusive images in a non-clinical sample.
Source: Rachman & de Silva, 1978

- Impulse to hurt or harm someone
- Impulse to say something nasty or damning
- Impulse to be violent toward young children
- Impulse to throw a child out of a bus
- Impulse to push someone
- Impulse to say inappropriate things
- Impulse to jump off a train platform

Figure 5.4. Intrusive impulses in a non-clinical sample
Source: Rachman & de Silva, 1978

As Veale et al. (2009) state:

> Intrusive thoughts are part of being human and if they are upsetting, this indicates a person's values. Thus, religious people are upset by blasphemous thoughts, moral people are upset by thoughts of acting immorally, and so peace-loving, gentle people with high standards of behaviour and a strong sense of what is right and wrong are upset by sexual or violent thoughts. . . . A person with OCD is at no greater risk of causing harm than is any other member of the public (they may even be at a lower risk). . . . A search on the database of the special (high-security) hospitals in England revealed no patients with sexual offences admitted with a diagnosis of OCD since records have begun. The collective experience of OCD specialists from around the world shows that obsessions about causing harm do not lead people to harm others. . . . People with OCD should not avoid cues that may trigger

> their obsession or make them worse and they should try to resist the urge to rationalise their experience or repeatedly reassure themselves. . . . Rationalising and reassuring are covert compulsions which maintain their obsessions. . . . Thus, a young mother with OCD can and should be left alone with her baby when using kitchen knives or other items that have been avoided due to her fear of causing harm. The man worried about stabbing his partner might be encouraged to sleep with a knife by his bedside; the woman worried about intrusive sexual thoughts should be playing with children in the way they normally do—the clinician should tell her that if they had children they would be happy to hire her as a baby-sitter. . . . Showing physical signs of sexual arousal is not a sign of being a paedophile—anxiety, selective attention and monitoring arousal in one's genitalia can increase these signs. (Veale et al., 2009, pp. 332–343, 338. Reprinted with permission)

Patients may benefit from self-help books that discuss these issues in more detail; of course, self-help books are not a substitute for treatment (e.g., Veale & Wilson, 2005; Abramowitz, 2009; Challacombe, Oldfield, & Salkovskis, 2011).

Informed consent and educational interventions involve discussion of therapeutic processes, potential benefits, and potential risks. Realistic hope about treatment outcome based on the evidence base relevant to each person as well as the factors that optimize treatment response (e.g., treatment adherence) are communicated, of course without any guarantee as to outcome. Steps that will be taken to optimize outcome are discussed on an ongoing basis. Frequently reported experiences during proposed interventions are discussed. For example, patients are informed that they will be provided with coping strategies during cognitive therapy but that these will likely not eliminate feelings of distress that accompany behavioral experiments or graduated exposure to feared events. Exposure to feared events, however unrealistic the fear, reliably evokes distress: learning how to adaptively handle strong feelings is required, as is the case in real life (Sookman, 2015). In order to normalize the process of ERP, as noted by Foa, Yadin, and Lichner (2012):

> Exposure in vivo is the natural way in which we reduce fears in ourself and our children. Examples include learning to ride a bike in spite of the danger

> of falling off, approaching a swimming pool in spite of the danger of drowning, staying in an unlit room in spite of fear of the dark, learning to drive a car in spite of fear of driving, etc. (Foa, Yadin, Lichner, 2012, p. 49)

Again, prior to and during *therapeutic* exposures, adaptive strategies are offered to reappraise unrealistic threat beliefs and to modulate emotional responses. Realistic risks of behavioral experiments or ERP should not exceed those in "normal" life (e.g., using public washrooms or taking the subway without rituals or avoidance). Strategies to handle emotionally difficult moments are collaboratively planned in advance whenever possible.

Psychological Interventions

As above, the evidence-based psychotherapeutic treatment of choice for OCD is specialized cognitive behavior therapy (CBT) including cognitive therapy, with exposure and response prevention (ERP) and/or behavioral experiments (BH). Specialized treatment targets the specific subtype symptoms and related difficulties of each individual. Decades of controlled outcome research have demonstrated that psychotherapy or "just talking" is ineffective for OCD and that application of specific interventions is required. ERP involves helping individuals to gradually face what they (unrealistically) fear combined with resisting urges to ritualize to reduce distress. Cognitive therapy and behavioral experiments precede and are combined with ERP for many OCD patients. Cognitive therapy targets appraisals of intrusive thoughts and associated feelings, intolerance of distress (e.g., fear, disgust, feelings of incompleteness, "not just right"), urges to ritualize and avoid, and other experiences characteristic of OCD. Characteristic beliefs (OCCWG, 2003) targeted include overestimation of threat, intolerance of uncertainty, overimportance and overcontrol of thoughts ("a thought is as bad as an action"), excessive sense of responsibility (e.g., "if a world war breaks out anywhere it is my fault"), and perfectionism (e.g., "I am not allowed to make any mistakes").

Case conceptualization and treatment planning are carried out collaboratively with the patient and evolve throughout treatment. In vivo interventions are discussed prior and agreed upon (please see subsequent

chapters for case illustrations). Importantly, intensity and location of treatment are responsive to the needs of each individual. Many patients do not respond to in-office ERP or behavioral experiments because their fears and rituals occur only at home, at school, or in public places. Many patients are able to face their fears only when assisted by the therapist. Therefore, when a time-limited trial of once-weekly in-office sessions is ineffective, treatment should be intensified (e.g., prolonged sessions of 90 minutes to 3 hours, three or four times weekly), therapist assisted, and administered in naturalistic environments. Treatment includes therapist fading, generalization, and relapse prevention strategies. Booster sessions are offered as needed. Although treatment is generally most effective on an individual basis, CBT administered in a group can be helpful for select individuals. A subset of severely ill patients require hospitalization for intensive CBT combined with pharmacotherapy.

Homework is integral to CBT and aims to systematically facilitate and generalize change to "real life." Self-administered homework assignments are varied and typically include facing feared or difficult situations with practice of adaptive skills discussed during cognitive therapy sessions. Behavioral experiments are planned to disconfirm unrealistic expectations and dysfunctional beliefs and to strengthen coping with feelings. Adherence to homework is an important predictor of outcome and requires ongoing assessment (Simpson et al., 2011, 2012). Specific assignments are recommended but should not be forced. Noncompliance should be handled non-judgmentally and explored with respect to meaning. The possibility that the assigned homework is not appropriate or is mistimed and requires collaborative adjustment should be considered.

Given that OCD has a serious effect on normal development, on skills acquisition, and on self-esteem, a recovery model of intervention involves varied skills acquisition interventions to remove obstacles that impede or may continue to impede normal development. These include but are not limited to strategies for emotion identification, modulation, and appropriate expression; interpersonal and assertiveness skills; academic or work rehabilitation (e.g., study skills, tutoring); and varied strategies to improve self-esteem and resilience (e.g., Padesky & Mooney, 2012).

Family Interventions

Research indicates that accommodation to OCD symptoms and family conflict are among the important predictors of poorer response to treatment for OCD, and supports the active inclusion of family in treatment (Steketee, 1997). Reports of family interference and high levels of distress due to symptoms are well-documented. Many families or significant others wish to and have the potential capacity to help but require the skills to do so. While accommodating to symptoms, significant others may inadvertently undermine appropriate autonomy and adaptive areas of functioning. Significant others are therefore actively involved from inception unless contraindicated (e.g., the young adult is involved in normal separation-individuation, progressing well, requests family not be involved; medical illness). Family involvement includes psycho-education, reduction of shame and blame, and specific recommendations to reduce accommodation to illness and to promote developmentally appropriate autonomy. Recommendations are commensurate with the patient's progress in treatment, are decided upon in collaboration with the patient prior, and are often communicated by the person in therapy. In general, abrupt cessation of accommodation or safety behaviors is contraindicated until the patient is deemed to be ready. Family interventions involve attention to the developmental stage and concomitant levels of cognitive and socio-emotional skills of the patient, awareness of the patient's involvement in and dependence on a family system, and incorporation of significant other-training and behavior management techniques. Support groups for families or significant others can be helpful (e.g., Van Noppen & Steketee, 2003). Involvement of a family member in ERP can be very helpful (please see case illustration in Chapter 7).

Chapter 6

Treatment of Obsessions

Chapters 6 to 10 will review specialized treatment approaches for OCD subtypes with case illustrations. These specialty interventions are not all-inclusive. The interventions outlined overlap and are combined to achieve synergistic impact (e.g., ongoing collaborative case conceptualization, provision of corrective information, cognitive therapy interventions, ERP, behavioral experiments). For those many patients who present with a myriad of symptoms, the interventions described are applicable on an individualized basis. Treatment for obsessions is described and illustrated first because these strategies are applicable to most OCD symptom subtypes. Interventions described in this chapter build on the work of Salkovskis, 1985; Salkovskis, Shafran, Rachman, & Freeston, 1999; Freeston et al., 1997; Shafran & Rachman, 2004; Rachman, 2003, 2007; Radomsky, Shafran, Coughtrey, & Rachman, 2010; Wilhelm & Steketee, 2006; Sookman & Steketee, 2010.

As Rachman (2003) noted:

> Only a small proportion of one's daily thoughts are the result of deliberate selection. Even that small proportion of our thoughts that is deliberately chosen does not necessarily move in the direction, or reach the conclusions, that we seek . . . if the person interprets . . . thoughts as increasing the probability of misfortune, or interprets the thoughts as having great personal and negative significance, then psychological problems can arise. (p. 36)

Cognitive therapy developed for obsessions involves helping patients to identify and modify dysfunctional appraisals, emotional responses, and information processing (e.g., selective attention, hypervigilance, thought-action fusion, emotional reasoning) in response to intrusions perceived as dangerous combined with behavioral experiments for emotionally meaningful disconfirmatory learning. Please see Freeston et al., 1997 and Whittal, Woody, McLean, Rachman, & Robichaud, 2010 for outcome data on the efficacy of these approaches.

Behavioral experiments involve predictions of how the person will feel, behave, and the outcome (e.g., 0–100% probability) compared with what actually occurs. The aim of these exposures is repeated disconfirmation and gradual modification of unrealistic expectations, beliefs, and emotional and behavioral responses. Complete exposure refers to gradual or rapid (flooding) entry into feared situations with elimination of avoidance. Complete response prevention refers to complete cessation of rituals (cognitive and behavioral). ERP can be administered gradually, with complete response prevention at each step, as will be illustrated in this chapter. Theoretically, a combination of the rationales of habituation ("my anxiety will eventually go down") and disconfirmation ("my fear is unrealistic; rituals and avoidance perpetuate my unrealistic fear") are optimally effective for many patients. However, immediate disconfirmation of perceived threats may be difficult if these are not imminent. For example, a strictly vegetarian patient feared falling ill with "mad cow disease" at some time in the future because of inadvertent contact with traces of meat; a 21-year-old student reported intrusive thoughts and cognitive rituals related to fear he would "end up in hell" when he dies an old man because of "perverted thoughts about Jesus." As Rachman (2003) has pointed out, cognitive and behavioral interventions may both operate by disconfirming key misinterpretations.

Treatment of Obsessions

Psycho-education and Goal Setting

- Unwanted intrusive thoughts are a universal phenomenon.
- Content of obsessions is closely connected to the person's values.

- Thoughts become obsessional if they are misinterpreted as having catastrophic meanings.
- As the personal significance attached to unwanted intrusive thoughts increases, their frequency and the level of distress also increase.
- When the personal significance attached to unwanted intrusive thoughts is reduced, their frequency and distress generally decrease.
- Covert and overt neutralizing, avoidance, concealment, and internal reviews perpetuate OCD.
- Attempts to neutralize, correct, or suppress obsessions may relieve anxiety in the short term but perpetuate unrealistic beliefs about significance, feared outcome, and distress.
- Avoidance prevents disconfirmation (e.g., "If I had not avoided knives, I would have experienced my thoughts and might have lost control of myself and acted on these.").
- Feelings of distress that arise from unwanted intrusive thoughts generally diminish spontaneously without neutralizing.
- Cognitive therapy strategies such as reappraisal of intrusive thoughts, emotions, and feared situations are recommended and practiced to enhance learning and adaptive responses to distress during behavioral interventions.
- Information processing biases that perpetuate OCD and require reappraisal include thought-action fusion and emotional reasoning, etc.
- Dysfunctional beliefs that perpetuate OCD and require reappraisal include overestimation of threat, overimportance and overcontrol of thoughts (and fear of losing control), inflated responsibility, intolerance of uncertainty, and perfectionism.
- Outline and discuss rationale and methods for cognitive therapy (e.g., above), exposure and response prevention, and behavioral experiments.

Cognitive Therapy

- Discuss evidence relevant to significance of intrusive thoughts and feared consequences (e.g., "What will happen if I touch knives and stop neutralizing?").

- Assess appraisals and beliefs about intrusions, reasons for believing these, and self-doubt (e.g., "What if I lose control and do a horrible thing?").
- Identify safety behaviors such as hypervigilance, concealment, self-monitoring, thought suppression, neutralization, reassurance seeking, avoidance, and escape behavior, and the feared consequences of stopping these.
- Generate alternative appraisals and explanations for intrusive thoughts that are more adaptive and realistic (e.g., perceived meaning about self; frequency of aggressive, sexual, or blasphemous thoughts compared to frequency of losing control and acting on these).
- Label intrusions as meaningless, harmless background noise whose frequency is increased by maladaptive responses (hyperattention, hyperarousal, misappraisals, rituals, and avoidance).
- Reappraise varied safety behaviors as harmful (i.e., they perpetuate dysfunctional beliefs) and plan their reduction.
- Assess and reappraise meanings of neutralizing (e.g., prevents feared outcomes, "It's the only way I can feel I am a moral person").
- Practice a three-step protocol that involves reappraisal, distance (metacognitive), and distraction for symptom-related thoughts and feelings as an adaptive "attitude."
- Practice corrective strategic processing (please see case illustration in this chapter).

ERP and/or Behavioral Experiments

- Plan with a specific stated purpose (not too challenging, initially).
- Optimize the probability of success (e.g., identify behavioral experiments that are commensurate with the patient's current skills with consideration of environmental/interpersonal factors).
- Help the individual to overcome avoidance and safety behaviors.
- Strengthen alternative interpretations of intrusive thoughts.
- Collect direct, personal information pertaining to symptom-related beliefs.
- Predict what would happen if the patient refrained from cognitive rituals and avoidance, etc., at an arranged time and place.

- Test the belief that the safety of self or others is decreased by intrusive thoughts and increased by rituals.
- Recommend the patient try not to fight or suppress obsessions and engage in response prevention for cognitive rituals.
- Repeat graded and planned exposures to feared situations, combined with cognitive-emotional strategies to promote relearning and to reduce fear and avoidance.
- Seek advice from a spiritual guide for religious intrusions, if needed.
- Demonstrate that discomfort will generally decline in response to cessation of neutralizing behaviors combined with adaptive strategies.
- Removal of unrealistic appraisals is not sufficient; therapists should collaborate in strengthening alternative more adaptive appraisals.
- Review conclusions from each experiment.
- Change in interpretations, degree of conviction, and believability can be gradual.
- Monitor adherence to homework.
- Reduce family accommodation commensurate with the patient's progress.

Case Illustration

Peter was as 65-year-old librarian who reported on initial assessment that he had suffered from OCD for more than 30 years. He had been married for 18 years and had two adult children, a daughter and son (both married). He reported that his wife "left me because she just couldn't stand my OCD anymore, I was always so preoccupied." Peter described his presenting symptoms as follows: "I feel compelled to look at breasts and crotches of people I meet. I look at the crotches of both sexes, I feel extremely bad thinking I may be looking at men, old women, or children." Peter reported, "I'm obsessed about whether my looking means I am gay or a pedophile. Do other people notice and think I'm a pervert?" Peter was able to perform his work as a librarian, though he said he spent hours obsessing at the end of each work day. His work reviews were invariably excellent. Once retired, he became increasingly socially isolated for fear that interpersonal contact would provoke symptoms.

His avoidance extended to his children; for example, he declined invitations even at Christmas: "If they notice me looking at them in a weird way they won't love me anymore. I can't take that chance." Peter reported extreme interpersonal sensitivity and perceived rejection: "If the clerk in the supermarket does not smile maybe he notices something weird about me and does not like me . . . I know no one can read my thoughts but my discomfort shows and maybe my eyes wander where they shouldn't . . . I am out of my control. My world has shrunk to only these thoughts. I order groceries to be delivered. I am afraid to walk on the street . . . I have thoughts of killing myself because I think I'm such a bad person . . . the only thing that stops me is this would hurt my kids, but for myself I have nothing to live for." Reported treatment history included several previous of trials of non-specialized therapy, with little success. According to Peter and confirmed (with consent) by his previous therapists, once-weekly general CBT for a year had involved education and attempts at ERP with little cognitive therapy. Peter reported: "The therapist said CBT wouldn't help me because I was not willing to face the situations I'm scared of . . . I feel it's hopeless for me." Peter reported taking Prozac (40 mg) for 20 years (higher doses "made no difference") and that he had an "18-year-long prescription" for Rivotril (.5 mg prn). He said he felt the medications were helpful. Peter said that he could not leave his house and risk even superficial contact with people without Rivotril. On initial assessment his Y-BOCS scores were in the severe range (35). On the OBQ-87 he ranked in high OCD range on overimportance and control of thoughts, overestimation of threat, intolerance of uncertainty, and perfectionism, but his scores on the responsibility subscale were not elevated. He reported very severe thought-action fusion and emotional reasoning. On the Vulnerability Schemata Scale (Sookman, Pinard, & Beck, 2001) three of the four subscales were highly elevated: perceived vulnerability; difficulty with unpredictability, newness, and change; and excessive need for control. His score on the BDI was 25. Quality of life was poor and GAF was 30.

Peter received 35 individual once-weekly sessions in our clinic. Treatment began with education about intrusive thoughts as described earlier, including discussion of thought-action fusion and emotional reasoning. Thoughts such as "If I have sexually deviant thoughts, I must

be perverted" were reappraised as personally significant ego-dystonic thoughts related *to his fear about* sexual orientation rather than his actual sexual orientation. Disconfirmatory evidence was reviewed: Peter had never engaged in sexual acts with a man, thought only about women when he allowed himself to masturbate, *obsessed with uncertainty* about his sexual orientation, and felt *anxious* in the presence of men but did not feel *sexual arousal* toward men (compared with his feelings and thoughts with his ex-wife). His overt behaviors and their meanings were also reappraised. For example, Peter feared that his "gazing at others" was equivalent to sexual attraction and, further, that this would be appraised the same way by others. His behaviors were reappraised as rituals to "check if I am looking in a weird way" and to verify the reactions of others in response to his distressing obsessions. Alternate appraisals of perceived rejection by others were explored; for example, "people look uncomfortable with me because they can see I am looking at them inappropriately, they think I am coming on to them, they think I am a pervert and feel disgusted" versus "people may see I look uncomfortable, they feel sympathetic, they are not sure how to act." Homework included ongoing reappraisals of involuntary intrusive thoughts ("I am gay/a pedophile and others think that's why I look at them").

Peter was initially unwilling to engage in any behavioral experiments without Rivotril. He said that he felt he had been avoidant for so long he did not recall basic skills such as "small talk." Role playing and modeling of skills interventions were practiced with the therapist and with others in the clinic in preparation for graduated behavioral experiments. For example, with Peter's consent, an increasing number of doctoral students participated in sessions in which they carried on conversations with Peter about a range of topics. Peter declined the suggestion that a member of his family come to a session because "I'm just too ashamed . . . they'll never speak with me again." Instead, a time-limited family visit was planned that involved Peter's children and his four grandchildren (which had been avoided for 5 years). Prior to the first behavioral experiment, despite his insistence on taking Rivotril, Peter felt intensely anxious and feared that after a single visit "I'll be rejected by my family and will never be able to go back . . . I'll be devastated. . . . Maybe I'll kill myself." It was planned that Peter would ask his son Brian (with whom

he had been previously close) if he noticed Peter looking at anyone "in an unusual way" during the visit. Skills rehearsal and imaginal rehearsal of the situation preceded the in vivo event. Peter predicted that his anxiety during this situation would be 100%, and that this would "take days" to go down; he predicted the chances were "85%" that his son would notice his roving eyes, fear for the children, and reject Peter. Peter said the figure was 85% "because there is a chance that Brian will lie in order not to cause a scene." Peter reported the following as a result of the behavioral experiment: The family had dinner at Brian's house and although Peter recognized efforts were made to include him in conversation he said little and kept his eyes on his food. Later, with much trepidation, Peter asked to speak with Brain alone. During that conversation he revealed that he suffered from OCD, that he feared he might look inappropriately toward children or men, and that shame and fear had kept him isolated from his family for fear of rejection.

Peter reported that Brian responded with tears in his eyes, as follows: "Oh Dad, I wish you had told me this sooner. We thought you are very depressed and very shy (as you've always been). We have missed you terribly at family events. No one has ever noticed any special looks by you. We've been worried you must feel very lonely and you seem so preoccupied. I would trust you to babysit anytime alone with the kids . . . We love you very much." To Peter's surprise, his worst fears were disconfirmed. He was able to schedule another family visit a week later, without Rivotril, and said he felt that he could communicate more with his family. During the second behavioral experiment he played with his grandchildren for the first time in many years. Peter's activities were then expanded to daily walks, going to public places that were increasingly more crowded, spending time in parks where children were playing and swimming, joining a social club and gym, and entering the locker room to shower after working out. He practiced reappraising intrusive thoughts as he had rehearsed during sessions. Peter reported that the intrusions' valence, meaning, frequency, and intensity steadily decreased with each behavioral experiment and exposure to previously feared situations. At posttreatment Peter reported occasional intrusive thoughts that "do not cause much anxiety," no avoidance (i.e., complete ERP), "much higher" self-esteem, Y-BOCS of 7, BDI of 5, GAF of 75, and "excellent" quality

of life. He gradually eliminated pharmacotherapy under medical supervision. He reported babysitting alone with his grandchildren regularly. At 5-year follow-up, Peter's progress was maintained, he had a "steady girlfriend," his Y-BOCS score remained at 6, and his endorsement of dysfunctional beliefs was no longer in OCD range.

It should be noted that, of course, not all behavioral experiments or treatments proceed as well as described here, especially if these involve families with long-standing dysfunction. In setting up behavioral experiments collaboratively with the patient, it is important to conduct a thorough prior assessment to optimize the probability of disconfirmatory experiences.

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Chapter 7

Treatment of Contamination

This chapter builds on the work of Rachman (2003, 2006), Sookman and Steketee (2007, 2010), Coughtrey, Shafran, Lee, and Rachman (2012), Warnock-Parkes, Salkovskis, and Rachman (2012), Radomsky, Dugas, Alcolado, and Lavoie (2014), and Rachman et al. (2015).

Cleaning related to fear of contamination is reported by around 38–50% of OCD patients (Calamari et al., 2004). Contamination fears share overlapping features such as feelings of discomfort and dread, strong urges to wash and clean in order to remove feelings of dirtiness or disgust, and ongoing efforts to avoid recontamination. Common concerns tend to be culture-specific, with clinically presenting themes relevant to threats in a given society at a given time.

> Contamination is an intense and persisting feeling of having been polluted, dirtied, or infected, or endangered as a result of contact, direct or indirect, with an item/place/person perceived to be soiled, impure, dirty, infectious, or harmful. The feeling of contamination is accompanied by negative emotions among which fear, disgust, dirtiness, moral impurity, and shame are prominent. Typical examples of pollutants are fecal matter, putrefying flesh, urine, and decaying vegetable matter. In factious/dirty contaminants include contact with items or people carrying germs, public washrooms, door handles, contact with bodily products such as blood/saliva/semen, contact with people or places believed to be infected (e.g., blood, hospitals, places/people, HIV, etc.). Potentially harmful substances such as chemicals,

> pesticides, and certain foods can be sources of contamination. Mental contamination can be caused by associations with impurity, dirtiness, immorality, accusations, nasty memories . . . and by violations such as sexual assault, betrayal, manipulation. . . . The response can be summed up this way: "Avoid if you can, but escape (or wash) if you can't." (Rachman, 2006, p. 9)

There are three categories that will be referred to as contamination types, with many patients reporting mixed fears:

Type 1: Fear and avoidance of dirt, germs, or other contaminants such as chemicals related to fear of becoming ill or spreading illness to others, with washing rituals and safety behaviors in order to protect self and/or others.

Type 2: Similar stimuli associated with a feeling or physical sense of contamination, dirtiness, or disgust with rituals to "get rid of the feeling." There are generally no feared consequences reported except for dread and need to get rid of or avoid the *feeling or sensation*.

Type 3: Mental contamination (Rachman, 1994; Herba & Rachman, 2007; Rachman et al., 2015): Feelings of contamination in the absence of physical contact with a contaminant. "Mental contamination can arise without physical contact with a contaminant . . . Because it is non-physical in nature, people often have difficulty locating the source and bodily location of their dirtiness and may describe it as an internal or emotional dirtiness . . . washing is generally futile as the contamination is not physical in nature" (Herba and Rachman, 2007, p. 2805). The source of contamination is primarily other people, thoughts, and/or memories (i.e., mental events) rather than external substances, and there is less fear of spreading contamination to others. Feelings of dirtiness or contamination are experienced all over the body or "internally." The feared threats may be more difficult to identify (e.g., fear of "morphing" or taking on the characteristics of another person). Past experiences of violation or betrayal are commonly reported prior to onset of OCD: "a sense of being harmed by the intentional actions, or omissions, of a person who was assumed to be a trusted and loyal friend, relative, partner, colleague or companion" (Rachman, 2010, p. 304). Relevant to this conceptualization, in an experimental study Rachman et al. (2015) examined reported past experiences of betrayal in a student sample and found

that being asked to think about these memories led some participants to feel dirty and to experience an urge to wash.

> Bearing in mind a weakness of early cognitive theories of anxiety disorders, the work on mental contamination moved from general propositions to increasingly specific analyses, explanations, and treatment methods. Given the evidence that cognitions can produce and maintain feelings of mental contamination, the approach has focused on cognitive assessments and explanations. This is a significant shift in emphasis away from behavioral explanations and treatment tactics to cognitive explanations, assessments, and treatments. (Rachman et al., 2015, p. 169)

Some obsessions are more likely to induce feelings of mental contamination, such as repugnant sexual obsessions and incestuous images. If images are misappraised as expressions of incestuous intent, the person may further interpret these as revealing a "bad" part of their "personality." Feelings of internal dirtiness or pollution are typically associated with physical and/or mental cleansing. Other emotions reported include anger, shame, and humiliation. The process of self-contamination is experienced as very distressing and uncontrollable. If the self-contamination is linked to obsessions (usually sexual in content), recommended treatment is a combination of CBT for obsessions and for contamination (Rachman 2003, 2006).

There is evidence supporting mental contamination as a distinct construct that overlaps with, but is separate from, contact contamination (Bloch et al., 2013). Many individuals with mental contamination report symptoms of contact contamination, while few people with contact contamination present with accompanying mental contamination (Rachman, 2006). Bloch et al. (2013) in a study with a large sample of OCD patients (N = 454), found that 46% reported symptoms of mental contamination. In the absence of contact fears, mental contamination was reported by 10.2% of study participants.

Further Clinical Characteristics of Contamination Types

In Types 1 and 2, fear of contamination is reported from specific objects or situations such as dirt and germs, chemicals, or bodily secretions

such as blood or urine. In Type 1 there is excessive fear of contracting or spreading a disease—even a cold or flu—most often from dirt, germs, or toxic substances. Feared consequences include fear of becoming ill, dying, or spreading disease to others. These fears are associated with qualities of rapid and widening spread, pervasiveness, and non-degradability (e.g., Tolin, Maltby, Diefenbach, Hannon, & Worhunsky, 2004). A sense of vulnerability to contamination is commonly reported (Rachman, 2003). Attempts are made to terminate each episode by washing away the contaminant or its traces, but the *fear* of recontamination persists. Washing often continues for hours, may cause bleeding, and (though ineffective) progressively worsens. Rituals typically involve behavioral "decontamination" such as washing hands excessively and repeatedly, taking long showers, and frequent use of antibacterial wipes. Avoidance behaviors include wearing gloves, and using Kleenex or elbows or feet to open doors or to steady oneself on public transportation. There is evidence that patients report superior recall of perceived contaminated objects relative to anxious participants without this fear (Radomsky and Rachman, 1999).

In Type 2 patients do not fear becoming ill but instead often report feelings of disgust or "just not right." In both Type 1 and 2, generalization of sense of contamination is very common (e.g., accidental contact with soiled gauze spreads to all clothes, to car, everywhere at home, etc.). In Type 3, patients report feelings of contamination from a non-physical contaminant that may involve specific persons, evil, etc. Symptoms may occur in response to repugnant intrusive thoughts, memories, or mental images, and they may be associated with reports of emotional and/or physical violations such as degradation, betrayal, or abuse. Washing as well as checking (cognitive and/or behavioral) and reassurance seeking are characteristic.

Treatment of Contamination

Psycho-education and Goal Setting

- Present educational model of OCD (detailed in Figure 3.1 and in Chapter 6).
- Provide examples of common distressing fears.
- Emphasize that rituals and avoidance perpetuate fear.

- Distinguish between socially acceptable or endorsed cleaning behavior and cleaning that is excessive or inappropriate.
- Predict (without a guarantee) a gradual weakening of urges to wash during response prevention, combined with cognitive therapy strategies.
- Outline and discuss rationale and methods for cognitive therapy, exposure and response prevention, and behavioral experiments.

Cognitive Therapy

- Identify individualized experiences, feelings, and beliefs relevant to contamination fears.
- Identify and reappraise symptom-related thoughts and feelings: for example, cues are emotionally upsetting but not dangerous (e.g., "I have been irreversibly exposed to illness and remain vulnerable; but the fact that I feel contaminated does not signify danger").
- Provide corrective information: for example, it is not possible to pick up undesirable characteristics from proximity to people; use of antibacterial soap and 4-hour showers are unrealistic.
- Differentiate between realistic and unrealistic threats.
- Collect evidence for and against key cognitions and feelings to strengthen reappraisals; provide contrasting explanations.
- Rehearse specific adaptive strategies prior to and during behavioral interventions (e.g., reappraisal of intrusions and distress).
- Practice a three-step protocol that involves reappraisal, distance (metacognitive), and distraction for symptom-related thoughts and feelings as an adaptive "attitude."
- Practice corrective strategic processing.

ERP and/or Behavioral Experiments

- Plan exposures to threatening places or people, combined with response prevention of washing, neutralizing, mental cleansing, etc.
- Construct experiments designed to collect direct personal evidence to demonstrate that thoughts are harmless.
- Collect evidence about experiences and beliefs in order to retest/reevaluate these before, during, and after in vivo experiments.

- Disconfirm in vivo information processing distortions such as thought-action fusion and ex-consequentia bias ("Because I'm scared there must be danger").
- Emphasize ERP exercises, therapist-assisted, primary for contact contamination and secondary (after cognitive therapy and behavioral experiments) for mental contamination.
- Employ ritual restriction, interruption, or delay as intermediate steps toward complete response prevention (if initially refused).
- Monitor adherence to homework and reductions in overestimation of unrealistic threats.
- Reduce family accommodation commensurate with the patient's progress.

Treatment of mental contamination requires development of adaptations and randomized controlled trials to examine these. For example, appraisals regarding persons perceived as contaminated, circumstances, and rationales for perceived threats are identified; evidence to support or disconfirm appraisals is collected; alternative, more adaptive, and revised appraisals of the threats are developed; and behavioral experiments are planned to create disconfirmatory experience (Rachman, 2003; Rachman at el., 2015).

Case Illustrations

Case # 1[1]

This case illustrates the application of complete ERP using imaginal exposure and cognitive therapy followed by a flooding paradigm to address this patient's specific symptom and belief profile. Important participation in treatment by a family member during sessions and homework is illustrated, as well as involvement of the patient's entire family, who lived in Montreal (her sister and family). This patient's treatment was time-limited because she was referred from another country. This case has a long-term (7-year) follow-up outcome.

Michaela was a 47-year-old married woman, with three children, referred from a Middle Eastern country. Prior treatment reported was

10 years of twice-weekly psychotherapy ("to figure out my underlying conflicts"), one year of once-weekly CBT that ended a year prior to the referral to our clinic, several adequate pharmacotherapy trials that had included augmenting strategies, and a lengthy general hospitalization for severe secondary depression. These treatments had failed to improve her OCD and she had recently made a near-fatal suicide attempt. The 100 sessions of previous ERP and cognitive therapy, combined with pharmacotherapy, qualified her as treatment resistant (technical treatment failure due to prior intervention inadequacy).

Michaela's symptoms began 17 years earlier when she and her family moved to a different country for a year to accommodate her husband's work. Michaela felt unhappy there because of the restrictive culture, despite her elevated socioeconomic status. Her OCD began when workers came to her home to do repairs. They had raw beef for lunch, which is common in this culture. Michaela saw a drop of blood on the floor and recalled thinking: "That is so disgusting; look at the mess they made." She experienced a strong feeling of repulsion and asked her housekeeper to wash the floor. Michaela then scrubbed the floor herself and took a lengthy shower. Over a period of several months her symptoms rapidly generalized to the point that she became housebound, with virtually constant obsessions about the possibility that she had touched raw meat. On initial assessment in our clinic she reported incapacitating cognitive and behavioral rituals with typical patterns of contamination spread from raw-meat sources. For example, she felt her car had become contaminated as she thought about the possibility that the wind could blow particles into her car from delivery trucks that might have come into contact with raw meat.

Michaela engaged in extensive washing for about 6 hours daily at home, but she struggled not to require the same behavior from her husband and children. After her children went to bed she completed extensive washing of all objects that had come from the outside. She was hypervigilant about what her family brought into the house, repeated ongoing mental reviews of the extent of contamination, and had great difficulty delaying washing her hands for even a few minutes because of "intense urges to get rid of all feelings of contamination." She engaged

in lengthy hand washing more than 50 times a day, maintained "safe" areas in the home, and made repeated requests for reassurance. To her great sorrow, she had been unable to hug her children for many years, except when they were just out of their bath in pajamas. Affection and sexual relations took place with her husband after he had showered. She could not accompany her husband or children to any activities, had withdrawn from friends and relatives, and felt anxious and ashamed. Contributing to her suicidality, she felt that her children and husband "are better off without me." On initial assessment she that said she felt "hopeless" about getting better.

The only symptom-related beliefs Michaela reported were: "Raw meat is disgusting. If I touch it, I feel contaminated. I feel guilty about spreading contamination all over my home. It's not that anything bad will happen to anyone. I just can't face the feeling." Michaela said that she felt she had to wash until she felt better. Obvious information processing distortions were generalization and all-or-nothing thinking: "If one drop of raw meat gets on me, it spreads to everything." At initial assessment, Michaela's total score on the Y-BOCS was 28. Her scores on three cognitive measures (III, OBQ-87, VSS) were comparable to normals. Idiographic record keeping was implemented to assess weekly change in obsessions and rituals, the two symptom-related beliefs she reported, and a variety of feelings.

Michaela was the eldest of three sisters, with whom she reported having a good relationship. She described her childhood as happy and privileged, having been raised by "loving and liberal-minded parents." She felt she had a relatively good relationship with her husband "who sees men and women as equal. We love each other very much," though it was strained because of the severity of her OCD. Michaela reported, and seemed to manifest in sessions, good tolerance for and expression of other strong feelings. She appeared to be highly motivated. Despite thorough exploration of Michaela's attachment and developmental history, cultural and interpersonal experiences, and meaning to her of the perceived precipitating event, ongoing assessment did not suggest a hypothesis for Michaela's intolerance of this specific experience of disgust. Her developmental and premorbid functioning appeared to have been good, and there were no other identifiable skills deficits.

Michaela reported (and the therapist's written report confirmed) that previous CBT had included education about appraisal models of OCD and ERP, with both habituation and belief disconfirmation rationales. Previous cognitive therapy had addressed beliefs about the probability and extent of contamination and self-doubt (e.g., "Did I wash enough? Is the speck of meat that could have been there gone?"). Previous ERP was graduated and therapist assisted. This included looking at pictures of raw meat, walking past raw meat in the supermarket, driving within sight of food trucks, and, finally, touching raw meat "with one finger." Michaela had refused to confront the most contaminated stimuli, and she had been unable to follow response prevention instructions between sessions. She said she sometimes washed at home after sessions, for example, shampooing her hair many times. There was minimal change.

The primary cognitive therapy interventions in our clinic focused on strategies to help Michaela to tolerate and reappraise dreaded feelings of anxiety and disgust that appeared central to her prior refusal to engage fully in ERP. The therapist told Michaela that avoidance of these feelings perpetuated their intensity and her perceived inability to cope. Although the ultimate goal of therapy, of course, was to diminish her feelings of disgust and related symptoms, the initial goal was conceptualized as helping her to develop more adaptive *responses* to her inner experience. She was advised that (if all else failed) a recommended strategy was to *defuse* or disconnect her thoughts, feelings, and behavior and to follow the ERP "prescription" (see below) regardless of her inner experience. Michaela said that intolerance of distress and disgust had not been addressed in her previous therapy. She confirmed that she understood the rationale presented; that is, if she engaged in ERP these feelings were expected to diminish. She agreed she had to face her feelings. Nonetheless, Michaela said: "I feel I cannot, it's too intense." She asked the therapist to "go very slowly so my anxiety is not too bad."

In view of the failure of previous graduated exposure, the therapist recommended the contrary, telling the patient that she would be unlikely to get better unless she faced whatever painful feelings occurred and proposing that intensive exposure could more rapidly decrease these feelings. Given previous difficulty sustaining ritual prevention, ERP was constructed to prolong response prevention, following exposure with

the help of a family member. The therapist made it clear that ERP would not be offered until Michaela requested it.

Treatment began with several sessions of prolonged imaginal exposure (90 minutes) in which Michaela was asked to imagine two opposing motivational scenarios. In the first, she imagined facing distressing feelings of disgust for several weeks of intensive therapy by following the therapist's behavioral prescriptions and imagined going home able to physically express her love for her husband and three daughters, hugging them and sharing life experiences she had been missing. In the second scenario she continued to avoid raw meat and continued to suffer her crippling symptoms. Following three imagined exposure sessions Michaela stated: "I will do anything to have my life back. I want the ERP. I'll do my best to face it." Michaela stayed locally at her sister's home during treatment. Because of her trusting relationship with her brother-in-law Samuel, a close friend of her husband, she asked him to participate and he agreed.

The schedule and content of ERP were planned collaboratively in advance with the patient and her family. ERP was administered in 2-hour sessions, four times weekly, for 6 weeks—a total of 48 hours of ERP. Samuel attended all sessions and participated in the ERP and assigned homework for the first 2 weeks. Flooding involved the highest step on the hierarchy from the onset. Samuel was asked to bring a package of raw beef to the first ERP session. Each step had been clearly outlined and agreed upon beforehand. The therapist repeated the agreed-upon protocol and asked Michaela to follow this regardless of what she was thinking and feeling, as follows:

T. "Okay, Michaela, as we agreed, remove the covering from the meat with your hands."

M. "How can I do this? I have not done this for 17 years."

T. "You want your life back. There is no way around this."

M. *(Opens the package, shaking.)*

T. "Great. Now, as we agreed, touch the meat completely with both your palms. Put your palms on the piece of raw meat. Think of your daughters while you do it."

M. "I'm doing it but how will I feel afterward? There is blood on my hands now." *(She looks at her hands, and looks scared. Samuel tells her she is doing great and he is proud of her. He repeats the same exposure by also touching the meat.)*

T. "This is going very well. Now, as we discussed, let's do the next steps fast. You can pat your hands for a second on the paper towel once. Good. Now, touch your hair, your face, all your clothes, your shoes." *(Michaela does all this and begins to cry.)* "Now, why don't you and Samuel hug each other so he is also utterly contaminated" *(said with humor. They hug and Samuel says how pleased he feels. Michaela cries and laughs a little at the same time.)*.

M. "I can't believe I just did that. I just can't believe this."

T. "How do you feel, Michaela? You did great. You did really great."

M. "It's all over me now. I feel a very strong urge to take a shower to get it off me."

T. "I know, but you want your life back. Do you feel proud of yourself?"

M. "I am very scared. Maybe a little bit proud. I have had nothing to feel proud of for 17 years." *(She cries and Samuel puts his arm around her.)*

T. "Congratulations, Michaela! You have come closer to the life you want back so badly. Okay, now let's review the response prevention that is essential if we want the exposure we just did to work. You go home to your sister's and as you all agreed you touch everything so nothing is left untouched. This is very important, that there be no exceptions. Everything in the kitchen, every room. Lie in your bed, get under the covers with the clothes you are wearing now, and put your head on your pillow. Touch all of your belongings. Don't wash at all, not your hands or anything else, except to brush your teeth until tomorrow morning before your next session. As we agreed, Samuel will be with you. He will touch everything first and then you do the same as him. Okay? Any questions?"

At the second session the next day, Michaela reported that the RP had been carried out exactly as prescribed. She had experienced difficulty sleeping. Her anxiety had dropped from 100% to only around 70%. She reported she had experienced many obsessions about what she had done. The same ERP exercise was repeated four times during the first week, with much encouragement from the therapist and family. Therapist fading was rapidly implemented: At the end of Week One, Michaela repeated all the steps in the presence of the therapist and Samuel, but without any instructions from the therapist or modeling by Samuel. At her sister's home, it was recommended that she take the initiative in "contaminating" the entire house with Samuel only accompanying her. Week Two focused on normalizing a wide range of activities. First with Samuel or her sister, and then alone, Michaela bought meat at a supermarket, drove her rental car intentionally behind food trucks, ate at restaurants, and used public washrooms. At end of Week Two, Michaela was engaging in a

wide range of activities in and out of the home. She reported (confirmed by family) that she was ritual free. To her great surprise, she felt that her obsessions and anxiety had dramatically reduced and her feelings of hope and pride had greatly increased.

At Week Three, the therapist recommended that the patient additionally grill or pan-fry hamburgers and steaks daily for her family (treatment took place during the summer). Each step required was reviewed with the therapist beforehand (e.g., how to handle raw beef, use of utensils, serving, cleaning up). Given the duration of dysfunction, essential ingredients to the relearning process involved education about normal meal procedures and rehearsal of resisting inevitable occurrence of urges to engage in "just little rituals." As exposures became easier, Michaela asked if she should do the same with raw pork and chicken although these meats had bothered her less. The therapist recommended against this for realistic health reasons (not one of Michaela's concerns). Further education was provided about normal handling and preparation of these meats and other foods (e.g., brief hand washing after touching) and normal clean-up without rituals.

At Michaela's suggestion, during Week Three she began to volunteer at a butcher shop cutting meat and serving customers. The therapist said she could not have thought of a better idea. While Michaela still believed about 30–40% that raw meat was contaminated, she felt little anxiety and was able to joke with customers as she worked.

In addition to the daily exposures described, the therapist recommended that Michaela agree to see relatives who wished to travel to Montreal from the United States to visit her. Michaela said she had been socially isolated and ashamed of herself for so long that these encounters provoked much initial anxiety and urge to avoid. Social encounters were planned as behavioral experiments to test whether people would be judgmental as she feared or loving and joyous as she hoped.

Figures 7.1 to 7.4 show the results of idiographic record keeping Michaela kept on severity of symptoms, ratings of the cognitive and emotional aspect of belief about contamination, and changes in experience of feelings both negatively and positively valenced. Of special importance is the reported (by patient and family) elimination of rituals at Week Two, but persistence of the belief/feeling over several months

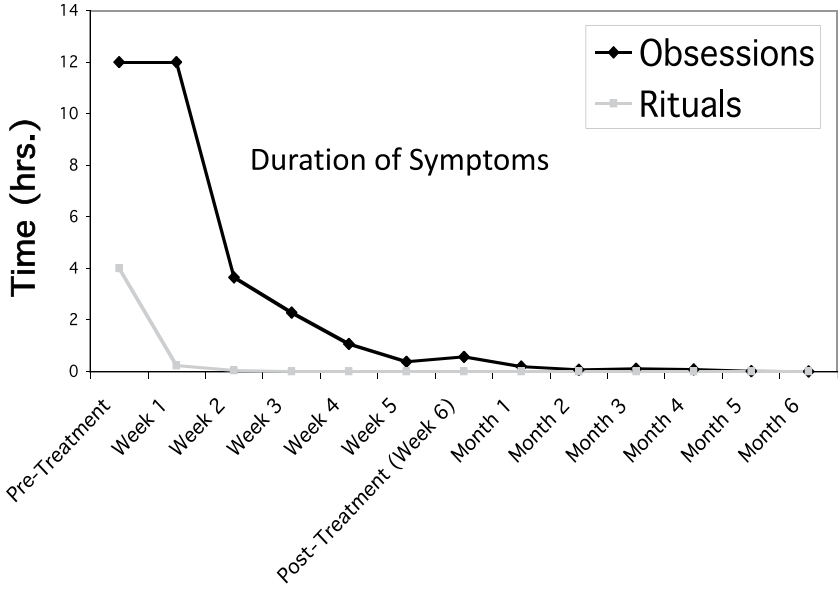

Figure 7.1. Michaela Self-Report of Treatment Response

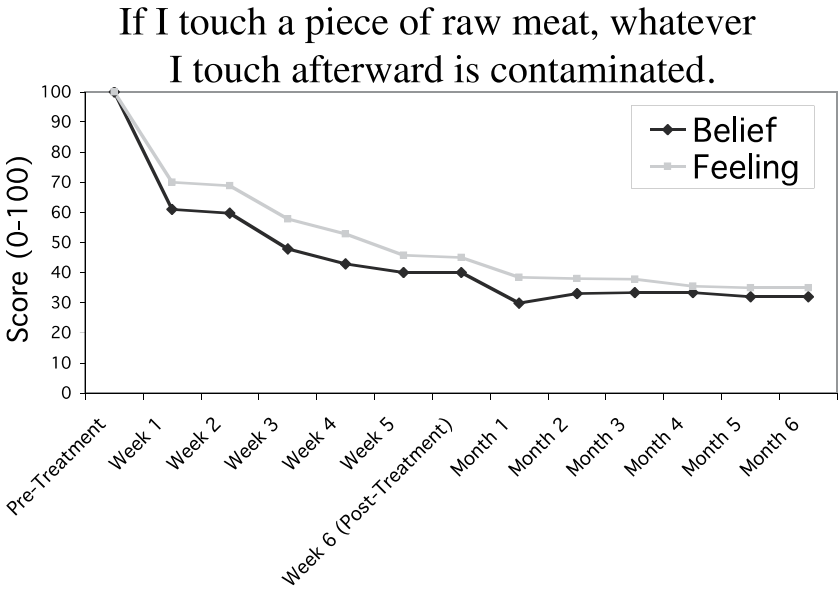

Figure 7.2. Michaela Self-Report of Treatment Response

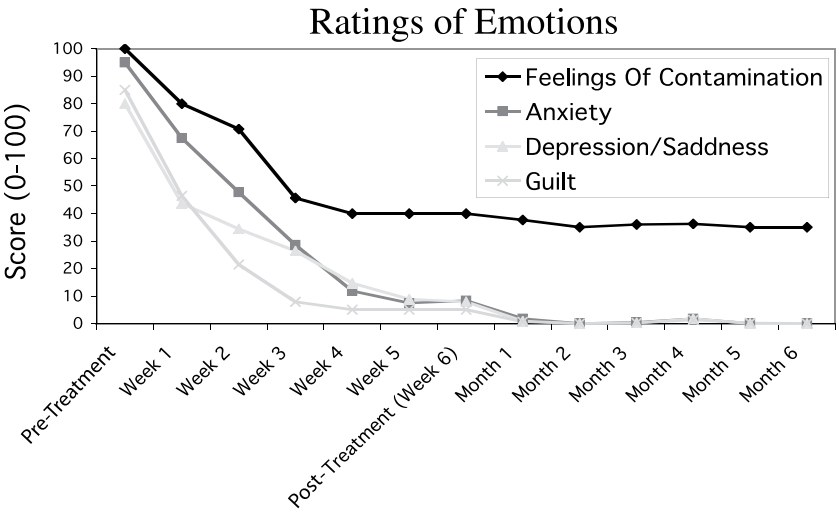

Figure 7.3. Michaela Self-Report of Treatment Response.

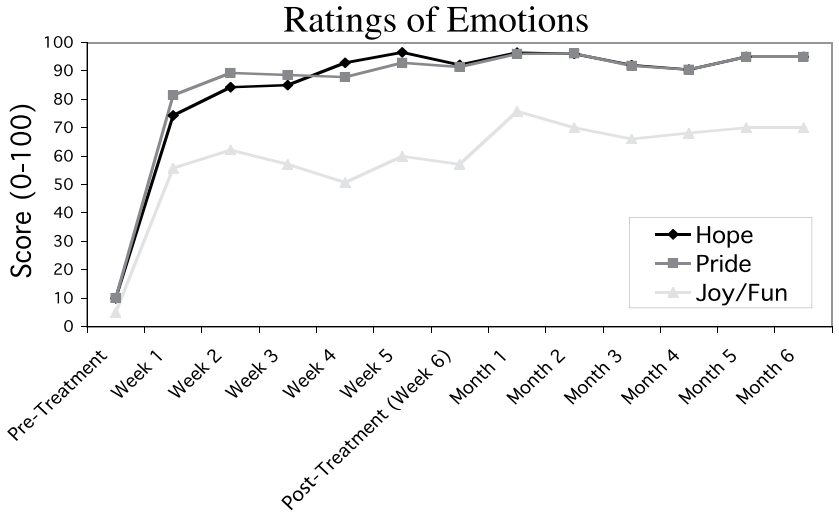

Figure 7.4. Michaela Self-Report of Treatment Response

that raw meat was contaminated (although this was gradually reducing). Importantly, Michaela reported that during this period she *more adaptively handled the feeling of contamination*. This record keeping also highlights the importance of monitoring other feelings, including positive feelings such as joy and hope.

The second half of Michaela's treatment involved detailed discussion of strategies for generalization and maintenance of gains in her home country. The therapist recommended a minimum of 6 weeks of intensive exposure (flooding), replicating the clinic procedures, and jumping into autonomous shopping, cooking, and traveling around the city immediately. This was to be followed by another 6 weeks of ERP three times a week, with gradual fading of formal exercises (provided there were no rituals or avoidance in her normal daily activities). Michaela gave advance instructions to her housekeeper and family to stop all previous protective and safety behaviors and reassurance. The therapist emphasized the crucial importance of maintaining complete exposure and response prevention regardless of the strength of urges to ritualize. Formal ERP exercises were to be resumed as needed to prevent relapse. Also of crucial importance was resuming varied activities in and outside the home with her husband and daughters, as she had longed for.

In order to help Michaela to adaptively cope with remaining feelings of contamination and urges to ritualize, as well as a central relapse prevention strategy, a technique was utilized called *Corrective Cognitive and Emotional Strategic Processing* (developed by Sookman and colleagues, see Sookman & Pinard, 2007).[2] This technique was formulated collaboratively, rehearsed during imaginal exposure, and given as homework. The following is an example of corrective strategic processing that Michaela practiced in order to resist urges to ritualize and in order to forestall relapse:

> I had a strong feeling of disgust touching raw beef for supper tonight (*emotional response to OCD trigger*). What if my OCD comes back? Oh, no, I'm getting anxious. Everything the meat touched is contaminated (*appraisal*). Maybe I should do something to clean up all traces of it (*urge to ritualize*). No! As I learned in therapy, this feeling is a false trigger. These feelings of

disgust and contamination are harmless, no matter how strong (*corrective processing*). My husband asked my opinion about an important decision today. This made me feel very happy, but I guess I also feel stressed (*corrective processing—identification of varied emotions, possible precipitant of symptom exacerbation*). I should try to figure out what's bothering me, talk to him, and deal with it (*problem solving to deal adaptively with emotions and relationship*). I have an urge to wash to get rid of this feeling that I am contaminated. But, as I learned in therapy, I can tolerate this feeling without letting it control my behavior. I will not let it affect my behavior because I do not want a recurrence of my OCD (*corrective processing*).

During the last week of treatment, Michaela's husband Stan and their children came to pick her up, and all went home together. Michaela introduced her daughters to the therapist, laughing and hugging them. During two couple therapy sessions planned from the onset, the procedure for ERP and normalization of activities at home were discussed with her husband with Michaela demonstrating. Her husband was astonished and began to cry. As Michaela had described, he seemed loving and supportive but understandably anxious about her illness and the possibility of relapse. He reported avoiding sharing his feelings or work difficulties with Michaela for fear she was "too fragile." He said he felt that the strain on him had been "enormous." The couple agreed to try to resume to function as equal partners, as they recalled doing before the onset of OCD. Before she left Montreal Michaela demonstrated her flooding paradigm on videotape and gave consent to show this to other patients who feared ERP.

The therapist offered Michaela weekly phone sessions for 6 weeks during the implementation of ERP and normalization at home, and then on an as-needed basis. She successfully generalized and maintained her improvement. Michaela reported she continued to feel about 30% "raw beef is contaminated," but this did not usually cause distress. Over the months that followed she reported several stressful periods where the urge to ritualize was very strong but she resisted because "I never want to get OCD again and I know ERP is my protection." Michaela returned to the clinic a year later for 2 weeks, following the death of a close relative. Michaela had not engaged in rituals but said that her urges were so strong she felt she was "in danger of giving in." Six sessions focused on

discussion of her feelings of loss, and the positive evolution of her relationship with her husband and children. At 7-year follow-up Michaela reported that she was completely ritual free and was engaging in varied activities with family and friends, with no avoidance. During this period she spoke with the therapist by phone an additional five times.

Why was Michaela able to engage fully in complete ERP, and in flooding, at our clinic and to maintain her progress at home? The patient attributed her success to five interventions: (1) emphasis on tolerating and coping with distress; (2) motivational imaginal sessions prior to ERP "helped me get in touch with how strong my feelings are of wanting to share life with my children and husband. I realized these feelings are as strong or stronger than what raw meat made me feel"; (3) therapist-assisted flooding and complete response prevention, "we went so fast, the anxiety went down fast, I didn't have to think about rituals because it was not possible to do them if I followed the prescription, I quickly learned I could cope with my feelings"; (4) imaginal and in vivo practice of corrective strategic processing during sessions and at home: "Strategies I learned and practiced during therapy, to prepare for going home, that I could use anytime to identify and cope better with what I think and feel"; and (5) Samuel's collaboration, which initially was indispensable to successfully complete ERP: "His support and encouragement also made me feel I could do it." Indeed, in the therapist's experience, Samuel was one of the best significant other co-therapists the author has ever encountered. He was loving, supportive, and he modeled coping. In collaboration with the therapist, Samuel helped Michaela to decatastrophize her distress, to focus on reality ("*it's just a feeling I can learn to cope with*"), and to envision the future she wanted.

Case # 2[3]

This case is presented to illustrate the application of graduated exposure with complete response prevention at each step, preceded by cognitive therapy that addressed this patient's specific symptom and belief profile. The case history routinely taken with all patients on intake is elaborated in Chapter 10. This patient's treatment was also initially time and content limited because she was referred from another city.

Mary was a 40-year-old single engineer referred after three outpatient trials of CBT (total duration, 4 years), several adequate pharmacotherapy trials that had included augmenting strategies, and a lengthy hospitalization for severe secondary depression had failed to improve her OCD. Thus, she could be considered treatment resistant (technical treatment failure due to prior intervention inadequacy). Her symptoms began 15 years prior when she accepted a position of supervisor of a state-run chemical disposal facility that included on-site assignments. Soon afterward she began to wash extensively each day after work. Within months, she had become incapacitated. No longer able to work, she found her feared stimuli rapidly generalized to all public places ("Someone at the site may have sat on that restaurant/subway seat, touched that doorknob, used that laundry") and then to all civil servants ("I can't touch my mail because the postman reminds me of that awful civil service job"). Thus, contact contamination evolved into associated mental contamination. By the time she arrived for treatment, Mary reported having moved across six states of the United States because each state "felt contaminated." Daily showers took 4 to 6 hours and she spent additional hours "Windexing" things. Mary arrived at the first session with plastic bags on her hands and feet.

Mary reported that she did not fear becoming ill but "just felt" contaminated. Finding this feeling unbearable, she washed until she felt better. Mary did not report appraisals/beliefs about overestimation of threat, thought-action fusion, or overimportance/control of thoughts. She did report hypervigilance for external cues, mental reviewing of the extent of spread of contamination, rehearsal of how much washing of what objects would be required, and an intense unremitting urge to get rid of feelings of contamination until she extensively washed herself and her belongings. Information-processing distortions included generalization and all-or-nothing thinking: "If one drop of dirt gets on me, it spreads to everything." At initial assessment, Mary refused to complete any forms to assess her symptoms or beliefs because she felt these were also contaminated. Clinician-administered Y-BOCS score was initially 30, although a few days later following complete assessment according to the patient this was more accurately rated at 38. She refused an inpatient-intensive CBT program and checked into a hotel for treatment.

Mary reported (and her therapists confirmed) that previous treatment had included education about appraisal models of OCD, with provision of both habituation and appraisal/belief disconfirmation rationales for graduated ERP. Previous cognitive therapy had addressed beliefs about the probability and extent of contamination, including, for example, reappraisal of the likelihood and degree of spread of contamination. Mary had refused to confront the most contaminated stimuli and had been unable to follow response prevention instructions between sessions. Change was limited and was not sustained.

The main cognitive therapy intervention before and during ERP in our clinic focused on strategies to tolerate and reappraise distress. Mary's pervasive response to painful feelings and sensations was to try to get rid of them. This appeared to be central to her refusal to engage fully in ERP—which would of course provoke the dreaded distress. Mary was informed that avoidance of her feelings was perpetuating her fear of and perceived inability to cope with them. The goals of cognitive therapy and ERP were reconceptualized as helping her to develop more adaptive cognitive, emotional, and behavioral responses to sensation and emotion. She was advised that if all else failed, she should defuse or disconnect her thoughts, feelings, and behavior and follow the agreed-upon prescription regardless of her inner experience.

The intensive phase of therapy was administered during 2-hour sessions, four times weekly, for 6 weeks. The therapist assisted in the ERP and assigned homework. The schedule of ERP was planned collaboratively with the patient, and each step was clearly outlined and agreed upon beforehand so it was predictable. The exposure hierarchy ranged from the first step of taking off plastic bags and going for a walk without touching anything to the final and most feared step of visiting a main lot in the city where garbage trucks parked, touching the side of a truck, and washing hands only briefly (normally) before eating. Complete response prevention during graduated exposure proceeded as follows: After she completed the first step, a 15-minute walk with no touching, Mary felt "horribly contaminated because a garbage truck went by on the other side of the street and particles flew off and contaminated both of us." It had been pre-agreed that the therapist would accompany Mary back to her hotel room to help ensure complete RP that had also been agreed

upon in advance. Without therapist assistance, Mary said she would have stripped naked and carried out a 4-hour shower before touching anything in the room. With Mary's prior agreement, the therapist (who was also contaminated) touched every object in the room, including all clothes and toiletries. Mary lay under the bedcovers in her "contaminated" clothes. Thus, complete exposure meant that no corner remained "safe." In Mary's view, this left the room in a state where decontamination was impossible, thereby eliminating her struggle about how much RP to do or not do. The only homework given was no washing (except brushing teeth) until the next day, and no changing of hotel rooms. To Mary's great surprise her discomfort decreased from 100 to 50 by the time the therapist left and to 30 by next day.

By Week Four Mary had completed the most difficult step on her exposure hierarchy, with much therapist modeling, and was initiating homework that involved exposure without rituals or avoidance to all previously avoided situations. This included using public transport, visiting government offices, and driving behind garbage and plumbers' trucks. By Week Five the therapist's involvement in exposure was faded so the patient completed all daily ERP alone. At Week Six Mary was symptom free in Montreal (no rituals and no avoidance), confirmed by therapist behavioral observation. The therapist and Mary then developed a plan to generalize her gains to her U.S. home, a plan she successfully achieved over two trips during the next month. Twice monthly booster sessions took place for another 6 weeks, for a total of 12 weeks of CBT. Relapse prevention strategies included imagined exposure of anticipated triggers with adaptive coping. Mary went back to school, changed careers, and became an accountant, a career at which she has successfully worked since. She subsequently married, saying this was the most intimacy she had ever been capable of.

Why was Mary able to engage fully in ERP in this trial but not previously? She attributed her success primarily to the cognitive therapy focus on tolerating/coping with distress, and to the procedure of therapist-assisted complete ERP. She maintained her gains at a 2-year follow-up, a critical issue for patients who are improved or recovered after treatment. However, over the 20 years I have followed her course, each significant life stress (e.g., death of her father) has been associated

with an exacerbation of symptoms ranging from mild to moderately severe. These symptoms have responded to booster sessions in which she returned to our clinic (the patient had refused our recommendation that she see a therapist locally for regular treatment). Had this patient lived nearby, weekly outpatient cognitive therapy would have been subsequently offered to address long-standing difficulties that her reported history suggests may have been linked to symptoms on a schema level (elaborated in Chapter 10). Among Mary's most difficult childhood experiences was the sudden death of her mother at age 4, the refusal of her father to discuss feelings about this loss, and his marriage within 6 months to his gym instructor, whom the patient felt was an intruder: "I felt completely out of control." Had it been possible to target emotional and interpersonal schemas during an adequate course of cognitive therapy following improvement of her OCD symptoms, Mary's improvement may have been more easily and completely sustained.

Case # 3

Alice was a 34-year-old single woman who suffered from severe contamination OCD. She reported feeling strongly that many stimuli—including garbage, used laundry, and her own bodily fluids—were dirty. She found menstrual blood, feces, and particularly nasal secretions to be "extremely dirty and disgusting." Thus, she reported both Type 1 and 2 contamination fears: with respect to external stimuli, she feared that exposure would lead her to become ill, particularly with serious respiratory and gastrointestinal viruses. She was housebound, unable to shop for herself, do laundry in her apartment, or walk past garbage cans on the street for fear she would become ill. A sole male platonic "friend" took care of her for a fee. On initial assessment, Alice reported (confirmed by her friend) that she had literally not touched or blown her nose at all for 3 years, even during respiratory illness. She had set up a "nose room" in her home. She entered this "highly contaminated room" once a week where during a 5-hour ritual she meticulously cleaned her nose with Q-tips and antibacterial soap. Following this ritual she took a 4-hour shower, making sure she did not touch anything in her home until she had cleansed herself. With respect to her own bodily fluids, she "felt contaminated"

and "disgusted" but did not fear illness. Alice's OCD had progressively worsened over a 15-year course. Several optimal trials of SSRIs with various augmenting strategies including neuroleptics had produced little reduction in symptoms. Prior to treatment in our clinic, Alice called the author in a "panic" stating that: "this is an emergency . . . a tiny piece of snot fell down in my nose room. I don't know where it is; I'm scared my entire house is contaminated now." Contamination was perceived as not degradable; she felt that once a section of her home was contaminated this would be the case "forever" unless extensive rituals were performed. Alice had not previously accepted CBT because "I can't stand the feeling . . . I have to keep avoiding and doing my rituals." She expressed limited insight. On "quiet reflection" she recognized that her experience was excessive, but in the midst of almost-constant feared situations Alice said that she experienced her fears as reasonable. Alice reported a "nightmare" childhood, with "an alcoholic father and critical mother." She finally sought treatment because she felt her suffering was "unbearable."

During the initial assessment, which included consultation with her treating psychiatrist, it was clear that Alice was too ill for outpatient treatment. She was admitted to hospital for a trial of intensive specialized CBT. Her Y-BOCS pretreatment score was 38 and GAF was 20; her scores on the OBQ-87 were in high OCD range on threat estimation, intolerance of uncertainty, and perfectionism, but not on overimportance or control of thoughts or responsibility. Initial attempts to perform a behavioral avoidance task of feared stimuli yielded limited results because she refused to approach even low-level avoided situations. Strength of key beliefs, subjective units of distress, and adherence levels were rated before, during, and following each cognitive therapy, behavioral experiment, and ERP session.

Alice received 3 months of intensive CBT four times weekly for approximately 2 hours each session. Treatment was delivered by a team of several senior doctoral psychology students under the author's supervision. Psychiatric staff collaborated in the CBT program and continuation of her pharmacology regimen. Nursing staff observed and rated adherence to homework. The educational and cognitive therapy phases involved the following commonly used evidence-based interventions for this OCD subtype: (a) education on normal washing and the role of

avoidance, rituals, and safety behaviors in perpetuating fear and other strong feelings such as disgust; (b) presentation of the rationale for ERP using both habituation and disconfirmation rationales (of dysfunctional beliefs and exaggerated emotional responses); (c) presentation of the rationales for disconfirmation of dysfunctional patterns using behavioral experiments; (d) strategies to reappraise and distance from thoughts, urges to ritualize, and strong feelings; (e) discussion of the metacognitive informational processing level and the possibility that Alice could as a first step feel strong feelings and at the same time learn to respond emotionally and cognitively differently to her own feelings (e.g., "I feel contaminated all over but this feeling, however strong, is a false signal"); (f) the need to tolerate and face distress in order to reduce distress; (g) motivational interviewing that focused on what Alice wished for (but felt was hopeless about achieving) in her life. Imaginal exposure with coping strategies preceded in vivo exposure.

Alice reported being essentially unable to use the strategies listed. Behavioral experiments of low-level situations designed to disconfirm did not result in change in reported beliefs or strength of feelings. In collaboration with Alice, it was decided that she would follow an ERP "prescription" regardless of her ongoing thoughts and feelings as "these are OCD." Specific safety behaviors decided upon collaboratively were allowed and then faded in graduated fashion. It was clear that Alice was too severely ill to collaborate in exposure without use of safety behaviors. For example, Alice had not touched a garbage can in a decade. The first time she touched the garbage can in her hospital bedroom, she used a plastic bag to cover her hand while briefly touching the garbage can with one finger. As sessions progressed Alice held the garbage can for increasing periods with the bag. Use of initial safety behaviors appeared to allow for the possibility of more prolonged exposure and for reappraisal that might not otherwise have occurred. Indeed, Alice explicitly stated that she would otherwise drop out. Behavioral experiments involved predictions by Alice of how badly she would feel, the strength of her urges to ritualize, etc., and these were re-rated after increasingly prolonged exposures. Similar procedures were used to help her to face normally touching and blowing her nose as well as many other previously avoided normal activities. To Alice's surprise, over time her anxiety

and feelings of disgust were progressively lower than predicted. Safety behaviors were gradually faded, for example, touching her nose with a Kleenex instead of plastic, then with her hand but allowing a normal wash afterward, then delaying the wash, and finally washing normally only after washroom use and before meals. Behavioral experiments and gradual ERP were implemented to a wide range of previously avoided situations. Therapist-assisted behavioral experiments and ERP sessions during home visits were conducted to generalize these changes to home. Levels of ERP completed in hospital were significantly more difficult at home, where the same procedures were utilized.

It should be noted that at the onset of treatment Alice regularly screamed and cried during treatment sessions, even though the components had been planned collaboratively in advance. At times Alice was reported to be so distressed she "hurled insults" at nursing staff (although she reportedly did not behave this way with the doctoral students working with her). Alice was diagnosed as having borderline personality disorder (BPD) and it was suggested to stop working on the OCD in order to "treat BPD" (I recommended against this, and treatment for OCD continued). While there are of course comorbid cases of OCD and BPD that may further complicate treatment, when Alice's OCD was sufficiently improved these "acting out" expressions of distress were much reduced.

Following 3 months of treatment, Alice's Y-BOCS score had decreased from 38 to 18. She was able to touch her nose and other body parts normally (she even had a cold during treatment). She was able to use public washrooms and do her own shopping, laundry, and cooking. The length of her daily showers reduced from 4 hours to 20 minutes. On discharge, as was planned, she joined a social group and initiated volunteer work at a site she would not have previously considered. Her feelings of contamination and disgust were reported to be significantly lower, but these persisted. Avoidance and safety behaviors had reduced but remained at significant levels, such as avoidance of touching common garbage cans without gloves, not being able to touch public toilet knobs or doors, etc.

On discharge, the treating team believed that Alice had made sufficient progress so that ongoing outpatient CBT could be delivered in

the hope of achieving further improvement. Alice was offered outpatient once or twice weekly CBT, with the plan of additional therapist-assisted prolonged home visits. Alice attended intermittently, saying she lived too far from hospital (1-hour drive, one way), her during and between session adherence reduced, and she dropped out of treatment against the team's advice. She tried therapy locally but reported that OCD was not addressed: "I cannot find an OCD specialist closer to home and it's too hard for me to travel so far."

At 5-year follow-up over the phone with Alice (and with her friend independently with Alice's consent) indicated that she had maintained some of her progress: for example, she could touch and blow her nose normally. However, there had been regression in many areas. Her Y-BOCS (clinician administered) had risen to 25 and there was significant interference in her psychosocial functioning and quality of life. Alice expressed gratitude for her treatment gains but she declined further CBT.

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Chapter 8

Treatment of Checking

As discussed previously, checking behaviors are associated with a wide range of intrusive thoughts and fears. The overall aim of treatment is to provide a less-threatening alternative explanation of the fear that is consolidated in cognitive therapy and parallel behavioral strategies. This chapter builds on the work of Salkovskis, 1996; Shafran, Thordarson, & Rachman, 1996; Shafran, 1997; Salkovskis, Forrester, & Richards, 1998; Salkovskis, Shafran, Rachman, & Freeston, 1999; Rachman, 2002; Wilhelm & Steketee, 2006; van den Hout, Engelhard, Toffolo, & van Uijen, 2011; Radomsky, Gilchrist, & Dussault, 2006; Coles, Radomsky & Horng, 2006; Radomsky, Shafran, Coughtrey, & Rachman, 2010; Shafran, Radomsky, Coughtrey, & Rachman, 2013; Radomsky, Dugas, Alcolado, and Lavoie, 2014.

> Thus, the person who believes that their intrusive thoughts indicate that they could be a child molester is asked to consider the alternative that they are particularly worried about being a child molester, and that they react to these worries in counter productive ways which have led them to develop obsessional problems. This formulation based cognitive-behavioural approach can, we believe, be enhanced by the clear identification of beliefs and the experiences, situations and critical incidents which have led to and interacted with these to produce their present problems. The crucial alternative explanation is strengthened by having a clear account not only of what is happening to maintain the beliefs and obsessional reactions but

also how such beliefs developed in the first place. (Salkovskis et al., 1999, p. 1070. Reprinted with permission.)

Treatment of Checking
Psycho-education and Goal Setting

- Psycho-educate about checking in OCD.
- Educate about theory of checking and its harmful effects: increases sense of responsibility, reduces memory confidence, impairs attention and concentration, and increases sense of loss of control.
- Illustrate common cognitive distortions such as excessive responsibility, and other maladaptive beliefs and biases.
- Contrast excessive responsibility and guilt to normal guidelines and experience.
- Discuss maintaining roles of maladaptive checking, safety behaviors, reassurance seeking, hypervigilance, and self-doubt.
- Present methods to modify threat estimates, catastrophizing expectations, cognitive biases, and related rituals.
- Discuss interventions to restore confidence in memory and concentration.
- Outline and discuss rationale and methods for cognitive therapy, ERP, and behavioral experiments.

Cognitive Therapy, Behavioral Experiments, ERP

- Identify symptom triggers as well as the extent and personal significance of feelings of threat and responsibility.
- Emphasize that the patient's difficulties arise from a problem of thinking.
- Establish baseline individualized estimates of the perceived probability and seriousness of feared threats and the degree of responsibility where applicable.
- Collect after the patient has completed a varied number of checks.
- Estimate the number of occasions the patient anticipated specific misfortunes or errors compared with frequency of misfortunes that actually occurred.

- Identify disconfirmatory information the patient ignores in order to reduce intransigence of strong feelings.
- Distinguish between provision of useful information and reassurance seeking that is not a request for new information (the patient has already checked and knows the answer).
- Response prevention for overt and covert (mental) checking.
- Reduce requests for reassurance by the patient.
- Plan behavioral experiments to demonstrate that most repetitive checking does not reduce the probability estimate of feared events.
- Plan behavioral experiments to disconfirm overestimation of threat and to distinguish between thinking about a catastrophe and its occurrence.
- Plan behavioral experiments to demonstrate the effect on memory and attention of repeated checking.
- Plan behavioral experiments to reduce thought-action fusion and excessive responsibility by *not* checking for safety, reassurance seeking, or cognitive rituals.
- Reduce hypervigilance to potential threats in situations that appear benign to others.
- Employ ritual restriction, interruption, or delay as intermediate steps toward complete response prevention (if initially refused).
- Practice transfer of responsibility, delay, and distance strategies (Radomsky et al., 2010).
- Practice a three-step protocol that involves reappraisal, distance (metacognitive), and distraction for symptom-related thoughts and feelings as an adaptive "attitude."
- Practice corrective strategic processing.
- Monitor adherence to homework.
- Reduce family accommodation commensurate with the patient's progress.

As Radomsky et al. (2010) have elaborated, a useful protocol to reduce thought-action fusion is construction of behavioral experiments with response prevention of checking for safety, reassurance seeking, or cognitive rituals. For example, behavioral experiments can be designed to demonstrate that thinking about a disaster does not increase its

probability of occurrence. Thought-action fusion and emotional reasoning biases raise anxiety and guilt and are associated with common counterproductive responses such as attempts at neutralization, covert checking, reassurance seeking, and safety behaviors. It is important to reduce hypervigilance to feared (though benign) threats during cognitive therapy followed by practice of response prevention during behavioral experiments and ERP to a wide variety of trigger situations. Patients who overestimate threat and believe that they have special responsibility for preventing harm to self or others are frequently vigilant for possible threats in situations considered nonthreatening by others.

Rachman, Radomsky, and Shafran (2008) and Radomsky et al. (2010) have proposed that safety behavior does not necessarily interfere with efficacy of ERP but, on the contrary, *judicious* inclusion of safety behavior (in the initial or difficult stages of treatment with subsequent fading) may improve acceptability of treatment and gains. Several studies have found that inclusion of safety behaviors during ERP sessions results in fear reduction and cognitive change comparable to exposure protocols in which safety behaviors are advised against or eliminated (Milosevic & Radomsky, 2008; Hood, Antony, Koerner, & Monson, 2010; Olatanji, Cisler, & Deacon, 2010; Rachman, Shafran, Radomsky, & Zysk, 2011; Sy, Dixon, Lickel, Nelson, & Deacon, 2011; van den Hout et al., 2011). Rachman et al. (2008) hypothesized that key potential advantages of judicious safety strategies during specific (early, difficult) phases of treatment may increase sense of control, tolerability, enhance confidence, and increase adherence. This hypothesis was supported by a recent study with contamination OCD (Levy & Radomsky, 2014).

Case Illustration

This case illustrates multifaceted interventions for long-standing severe checking symptoms and related difficulties. Mark was a single Caucasian man in his mid-forties, an only child, living at home with his father. His mother had died 10 years prior of cancer. Mark worked as a bus driver in a large city. Although he reported having had friends as a child and during his undergraduate studies in university, since the exacerbation of his OCD 18 years prior he was socially isolated. Mark reported that he never had

a girlfriend or any sexual experience with a woman (he had never kissed). On initial assessment, he stated he was convinced that his situation was "hopeless." He refused to complete any questionnaires, saying this would take him "months." Clinician-rated Y-BOCS score was 35 and BDI was 28. His main symptom, reported as incapacitating, was mental "listing" that began in college, related to "need to be perfect." No other precipitant was identified. The listing was experienced first as voluntary but rapidly became involuntary and was extremely repetitive. For example, before bringing his car to the garage for maintenance Mark would list his questions and the required servicing literally hundreds of times. Additionally, he also carried out extensive behavioral checking by Internet and phone to identify "the best garage in the city." Among many examples, he called 25 garages to check the cost of an oil and filter change every time this was due, although he always ended up using the same garage. He reported spending hours listing or doing Internet searches on possible opening lines for a conversation with a woman (e.g., "Hi," "Hi, how are you," "Hi, I'm Mark," "Hi, you look great . . . no, that's not right . . . "). He described the feared consequences linked to his cognitive and behavioral checking as follows: "I don't trust my memory; I may forget something important. I'm afraid to make a mistake. I list so I'll remember. I can't stop the listing until the event has passed. I have to check everything to make sure I am making the best choice."

On initial assessment, Mark stated that he did not believe that his difficulties were psychological: "I believe 100% that this is not a psychological problem. There is something wrong with my brain. I need psychosurgery." Fortunately, his two consultations for psychosurgery were refused and he was referred to our OCD clinic. Psychological and memory testing showed no memory impairment; on the contrary, Mark scored in the superior range for memory as well as IQ. Mark said that his symptoms interfered with his work as a bus driver but that he could drive safely. The only time he stopped listing was when he was actually driving. During the hours he was off work he spent all his time checking out unnecessary information and listing information related to upcoming minor decisions. Listing and checking pervaded every aspect of his daily life—"What color socks should I wear tomorrow?" "What is my grocery list?" "What will I have for dinner?" "How many hours sleep do

I need?"—with repeated itemization of every daily task. Mark was unable to read or engage in any kind of leisure activity because listing related to the activity would take too long. He said that he spent much of his spare time in bed (e.g., the entire weekend) due to severe secondary depression. In summary, the only urge Mark described was to list and check, and the only feelings he reported were secondary depression and hopelessness. With respect to prior treatment, Mark had sought "many therapies for many years, none of which helped the OCD." He had been prescribed various SSRIs, "none of which helped." On initial assessment Mark had been taking Celexa 60 mg and Risperdal 1 mg for 2 years "with no effect." The therapist and prescribing psychiatrist had the impression that medication was helpful in somewhat reducing his level of distress but did not have significant effect on OCD symptoms or secondary depression.

Treatment in our clinic included the following interventions: (a) reappraisal of symptoms ("I have no emotional problem. There is something wrong with my brain. I need psychosurgery"); (b) reappraisal, and response prevention for dysfunctional information and emotional processing, and for repeated rituals; (c) identification and labeling of feelings that over time Mark was able to express as profound sense of deficiency and fear of rejection; (d) strategies for intolerance of emotional distress; (e) behavioral activation, including social activities as an alternative to staying in bed from Friday night to Monday morning; (e) education, modeling, and practice of multiple skills strategies such as problem solving, decision making, and interpersonal, self-assertion, and self-expression skills; and (f) behavioral experiments and exposure and response prevention to test hypotheses, to reduce avoidance, and to practice new skills.

In summary, Mark's symptoms were reappraised as involving intolerance of uncertainty, perfectionism, rigidity and fear of spontaneity, and fear of failure and rejection *rather than memory impairment*. Therapy involved education, many skills interventions, behavioral experiments, and reduction of multisphere avoidance of inner experience and external events.

A series of behavioral experiments were collaboratively developed to disconfirm dysfunctional appraisals and emotional responses, and to improve normal decision making. Each behavioral experiment involved

predictions of feelings, process, and outcome, and post-hoc examination of predictions compared with what actually occurred. Examples were:

- If I tell my garage mechanic he overcharged me, he'll become offended and refuse to service my car again.
- If I assert myself, I'll be fired.
- If I disagree with my therapist, she won't want to see me again.
- If I don't prepare the perfect opening line, a woman I'm attracted to will find me boring and rebuff me.
- If I stop my listing, I will lose control and everything will fall apart.
- I'll forget everything important, I will fail at everything I try.

Behavioral experiments were constructed that involved graduated exposure (with practice of new emotional, cognitive, and behavioral skills) to the following: (a) events that provoked listing; (b) events that provoked previously avoided feelings; and (c) situations involving newness, unpredictability, flexibility, spontaneity, and uncertainty. As Mark began to conceptualize his difficulties as emotional, and to envision treatment goals, targets and steps to achieve these were identified. Mark successfully practiced making increasingly more important decisions without listing, using a variety of adaptive strategies practiced during sessions and behavioral experiments.

As discussed, severe OCD often pervades many aspects of psychosocial functioning that are targeted in an overall treatment plan for many OCD patients. For Mark, the capacity to express psychological goals represented significant progress. For example, he requested that we focus on reducing the intense feelings of anxiety and fear of rejection that he experienced when approaching women; he wanted to be able to talk with a woman without incapacitating intrusive thoughts about what she might think of him before, during, and after an event. Treatment included normalization, reappraisal, and coping with rejection (as well as success) and use of the therapeutic relationship to improve interpersonal skills with modeling and role playing while Mark practiced response prevention for cognitive rituals. The therapist modelled thought processes that were less rigid and more spontaneous, and reappraised beliefs about relationships: "Perfectionism leads to having a relationship" or "I'm

not good enough for this woman" compared with "Perhaps I intimidate women because I appear too uptight and formal. I'm so obsessed with mental checking about what I'll say next I'm not listening so my responses sound off." Mark's self-presentation such as posture, response to questions, and choice of clothing were also discussed. For example, Mark had not been shopping for new clothes in a decade. His hair was regularly cut short by an 80-year-old barber (with no talent for hair) and was smothered at all times with lotion "so it won't look messy." Mark asked a colleague for advice on these matters, though he feared he would be rebuffed. On the contrary, when the colleague learned that Mark was going shopping for clothes and needed a hair stylist she gave many recommendations. Mark arrived to the next session with a snazzy new haircut (without lotion) and updated clothing. He stated, looking rather dazed but smiling: "I feel like a new man" (indeed, the change in his appearance was striking).

Behavioral experiments involved Mark approaching and having conversations with several women. With continued practice of social skills in sessions and in vivo Mark joined a singles club and began (for the first time in his life) to date. He responded flexibly to a woman who asked him out. However, he then feared he was incapable of having an erection and could therefore "never have a relationship" and he requested this be a treatment target. Mark had previously dealt with this matter by obsessing about his performance and listing the percentages of full erection achieved every few minutes, strategies that unsurprisingly failed. Adaptive strategies involved focusing away from performance, reappraisal of feared consequences, increasing awareness of arousal, and exposure to sexual material (e.g., movies) combined with response prevention for OCD symptoms. Mark succeeded at this goal as well, he felt more confident when speaking with women, and again his predictions were disconfirmed.

Following 1 year of weekly treatment, Mark reported that his behavioral checking and listing were greatly reduced but not eliminated. Y-BOCS score had reduced from 35 to 15. On the OBQ-87 that he agreed to complete at posttreatment overestimation of threat, intolerance of uncertainty, and overimportance/control of thoughts were at the lower end of OCD range. BDI had reduced to 8. He was regularly dating

a woman, successfully "lost his virginity," and was more self-assertive. Generalization and relapse prevention strategies were outlined. These included using adaptive strategies and response prevention for listing and checking under stress, and continued exposure to feared situations. Mark received 20 booster sessions.

At 5-year follow-up Mark's Y-BOCS score was 8, beliefs were elevated compared with normal but no longer in OCD range, and he had moved in with his girlfriend (there were no sexual difficulties). He had discontinued medication under medication supervision. He reported enjoying varied leisure activities. For example, he had learned to dance and to cook, went to movies, and went biking and hiking with his girlfriend. When the therapist asked Mark at follow-up about appraisal of his symptoms Mark replied: "It's 100% psychological and always was."

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Chapter 9

Treatment of Symmetry, Ordering, Arranging

This chapter builds on the work of Summerfeldt, 2004, 2007, and Summerfeldt, Kloosterman, Antony, & Swinson, 2014.

There has been little outcome research on treatments for incompleteness OCD, with the exception of Tallis (1996), who described four patients with cleaning related to perfectionism and urge to arrange objects "just so." All showed modest long-term therapeutic response to ERP intervention compared with cognitive therapy or serotonin reuptake inhibitor (SRI) medication. Summerfeldt (2004, 2007) reported treatment of a few cases with limited response (approximately 30% improvement). This is consistent with the finding that OCD patients unable to identify feared consequences tend to show less improvement (45% versus 69%) compared with patients who report specific feared consequences (Foa, Abramowitz, Franklin, & Kozak, 1999). Symptoms and related characteristics most associated with incompleteness are often those identified as being least responsive to ERP; however, treatment of this subtype requires further examination.

Sense of incompleteness is commonly associated with symptoms of symmetry, counting, repeating, slowness, and a more complicated comorbidity profile. Some patients engage in repeating actions to obtain a "just right" feeling of completeness or satisfaction. Individuals with this OCD subtype report the urge to arrange or maintain objects and possessions in rigid ways, including preoccupation with order and symmetry.

For example, many need to make their bed "impeccably" with perfect wrinkle-free hospital corners and report intense anxiety if prevented from doing so. Hypervigilance and time-consuming rituals are reported to ensure things remain in the "right place"; repeated vacuuming and dusting to ensure there are no dust particles because of concern with "perfect neatness," washing down counters to remove all dropped particles "otherwise it doesn't feel right," checking before leaving and on return home to ensure there is nothing is out of place. Intense distress may be reported if the desired pattern is disrupted or if possessions have been touched.

Patients with this subtype usually do not fear impending danger; rather urges to ritualize are associated with a feeling or sensation of discomfort when things are not "perfect" or until it feels "right." Patients with thought-action fusion who report feared consequences (e.g., a member of my family will die) if objects are not aligned are not categorized into this subtype. That is, distressing or "bad" thoughts may also be associated with repeating rituals to keep a feared thought from coming true or to prevent feared disasters.

> These individuals do not describe anticipatory anxiety, but a tormenting sense of dissatisfaction with their current state. Motivationally, what dominates is not avoidance of harm but rather the drive to correct profound feelings of imperfection regarding the need for experiences to conform to exact, yet often inexpressible criteria. This subjective experience of conditions being "not just right" can be manifested through any sensory modality, including the visual (e.g., appearance of belongings or documents), auditory (e.g., preference for sameness in ambient noise), tactile (e.g., checking of textures by touching or tapping), and proprioceptive (e.g., needing to "even up" actions). It may also apply to more complex experiences that do not readily fall into the sensory category, such as cognition (e.g., expressing one's thoughts unambiguously, in the best words). (Summerfeldt, 2004, p. 1156)

Thus, emotional or sensory disturbance is the trigger and motivation for OCD behaviors. Cognitive therapy that involves reappraisal would therefore not focus on thoughts such as overestimation of threat (which is unlikely to be elevated), but on the individual's interpretation

of emotional experience. It is not clear whether feelings of incompleteness or just not right might be causal in development of beliefs such as: "There is a perfect way to do things, I'll feel better if I just get it right" (Summerfeldt, 2004).

Treatment of this subtype consists of several components, based on assessment of avoidance, triggers, and rituals: (a) hierarchy of ERP designed to provoke feelings of incompleteness with prevention of the rituals to alleviate related discomfort; (b) ERP aims to achieve habituation of sensory-emotional distress as well as its reappraisal; (c) cognitive therapy for reappraisal of experience (e.g., "This feeling is a false trigger I can tolerate; it will go down if I stop feeding it. This is misguided, unproductive, and futile. My aim should not be to perfect this") is combined with relevant ERP during sessions (e.g., reading school/work materials, writing checks, sorting). Cognitive therapy as well as behavioral experiments target the fear that without ritualizing feelings of incompleteness would persist indefinitely; (d) homework aims to create unpredictability, disarray, spontaneity, capacity to shift tasks, reduce perseverance, and to make decisions; (f) ERP is a lifestyle change rather than a situation-specific change (Summerfeldt, 2004); (g) ERP targets include duration as well as the inflexible sequence of activities and includes creating distractions and interruptions; (h) response prevention is applied to all related rituals such as checking, cognitive reviews, meticulous behaviors, ritualized sequences, need for sameness; (i) ritual restriction, interruption, and delay are used as intermediate steps toward complete RP; (j) repeated intrusions, distress, and preoccupation are cues to maintain and/or re-implement regular practice of ERP. A case illustration of treatment of this subtype with comorbid presentation is described in the next chapter.

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Chapter 10

A Schema-based Model

Multidimensional schemas that may underlie psychopathology and impact resistance to change have been emphasized in recent CBT conceptual models (Beck, 1996; Leahy, 2002; Beck, Freeman, & Davis, 2004; Leahy, 2007, 2010; Leahy, Tirch, & Napolitano, 2011; Beck & Haigh, 2014). Sookman and colleagues developed and examined a schema-based conceptual model and treatment approach specifically for OCD applicable to different subtypes, meant to be combined with and improve the response to evidence-based cognitive and behavioral protocols (please see Sookman, Pinard, & Beauchemin, 1994; Sookman & Pinard, 1999, 2007; Sookman, Pinard, & Beck, 2001; Sookman & Steketee, 2007, 2010).

> Cognitive schemas, defined as internally stored representations of stimuli, ideas, or experiences (Beck 1967), control information-processing systems (e.g., lower-order automatic processing versus higher-order reflective processing). When a schema is activated, corresponding meaning is derived from the belief and interacts with other cognitive, affective, motivational, and behavioral systems. Biased beliefs exist on a continuum ranging from adaptive to maladaptive and can be conditional or absolute. When the bias exceeds the built-in adaptive level, it increases the probability of an individual experiencing a subclinical or clinical disorder. (Beck & Haigh, 2014)

A common characteristic of patients who do not respond well to specialty CBT is the intransigent quality of their symptom-related appraisals and beliefs despite apparent contradictory life events: "I know I'm exaggerating the probability something bad will happen, but I still *feel* I'm in danger." Schema-based interventions for OCD in the Sookman et al. model are intended to expand upon standard cognitive therapy methods described previously; to improve collaboration with and accommodation during ERP, behavioral experiments, and skills interventions; and to enhance generalization and maintenance of change. Originally developed by Sookman et al. (1994), this approach stems from the hypothesis that dysfunctional schemas may interfere with adaptive learning (Rosen, 1989). Core beliefs such as "I am a vulnerable or dangerous person" may influence appraisals of thoughts and other strategic processing of internal and external events: "The fact that I have these thoughts means that I am a dangerous person and may act on them." Thus, schemas comprising beliefs, emotions, and memories about threat may underlie intransigent beliefs about threat related to symptoms (Sookman & Pinard, 2002). These schemas may contribute to risk aversion and difficulty engaging fully in behavioral interventions (Steketee & Frost, 1994). As contemporary CBT models suggest: (1) dysfunctional responses to internal and external events may reflect dysfunction at the core schema level, and (2) modification of the structure and content of dysfunctional schemas may be necessary to forestall recurrence of symptoms for some individuals (Beck, 1996; Beck & Haigh, 2014). Leahy and colleagues have focused on the important concept of emotional schemas (Leahy, 2002, 2007, 2010; Leahy et al., 2011), elaborating in theory and practice individuals' experience and regulation of emotion as central to the development and maintenance of psychopathology. Thus, individuals who believe that their emotions are out of control, dangerous, or will last indefinitely may be reluctant to approach their fears and to discontinue safety behaviors perceived as essential for protection.

Inclusion of schemas in the context of evidence-based protocols for OCD may be viewed as encompassing the individual's broader learning history that can contribute to current information processing. This addition may be particularly helpful if focusing solely on current

maintaining factors does not result in optimal relearning and symptom reduction. Concepts from attachment and developmental theory are integrated in conceptualization and treatment planning, thereby broadening the theoretical basis for case conceptualization and intervention. It is crucial to emphasize, however, that this does not mean "going back to" psychoanalytic theory or practice that is wholly ineffective for OCD. This distinction is apparent from numerous publications about schemas by A.T. Beck as well as other leading CBT experts such as J. Beck and R. Leahy. Further, importantly, these interventions are not recommended for use in isolation but are intended to be combined with evidence-based specialized CBT interventions. These interventions must be put to rigorous empirical test for OCD. Although there are difficulties in designing methodologically sound studies with complex interventions, there is ongoing refinement and development of new and complex interventions that constitute expansions of CBT models. Another important consideration of schema-based interventions is how to best disseminate expertise on their application. As reported in the literature, some OCD experts integrate these concepts, report on the potential impact of developmental experience on current symptoms, conduct downward arrow to identify core beliefs linked to symptoms*, but are doing so in the context of treatment that emphasizes evidence-based protocols* (e.g., Rachman, 2007; Wilhelm & Steketee, 2006; Sookman & Steketee, 2010). However, other therapists report protocols that address their patients' core beliefs and childhood but their treatment protocol in toto (or even in part) does not correspond with evidence-based protocols. The latter is inadvisable. The theoretical literature underlying the Sookman et al. model and related treatment approach will be briefly summarized in the next sections, followed by case descriptions to illustrate utilization of schema theory and interventions combined with evidence-based CBT treatment interventions.

Dysfunctional schemas have been shown to be a general vulnerability factor for psychopathology (Hawke, Provencher, & Arntz, 2011; Pinto-Gouveia, Castilho, Galhardo, & Cunha, 2006; Thimm, 2011; Rasmussen, Steketee, Silverman, & Wilhelm, 2013). There are growing references in the OCD literature to these important clinical phenomena. For example, Salkovskis, Shafran, Rachman & Freeston (1999) proposed multiple

pathways to inflated responsibility beliefs in OCD, discussing possible origins and implications for treatment and research as follows:

> Clearly, the evolution of such beliefs is likely to be a subtle and interactive process taking place over many years. . . . These possibilities include: (1) an early developed and broad sense of responsibility for averting threat that is deliberately or implicitly encouraged and promoted during childhood by significant figures and circumstances, leading to enduring and "justified" beliefs about the importance of a sense of responsibility; (2) rigid and extreme codes of conduct and duty; (3) childhood experience in which sensitivity to ideas of responsibility develops as a result of being shielded from it; this may include over indulgence, and/or may be the consequence of the implication or declaration of incompetence by those around the child; (4) a specific incident or series of incidents in which actions or inaction actually contributed in a significant way to a serious misfortune which affects oneself or, often more importantly, others and (5) an incident in which it wrongly appeared that one's thoughts and/or actions or inaction contributed to a serious misfortune. (p. 1060. Reprinted with permission.)
>
> The parents are likely to be excessively anxious and fearful themselves, and to convey a sense that danger is "just round the corner" as well as the notion that the child may well be incompetent to deal with such danger were it to materialise. In some cases the parents may even model some behaviour that resembles compulsions. The child is likely to develop beliefs such as "Prevention is better than cure," "Better safe than sorry." (pp. 1062. Reprinted with permission.)

Although most progress to date in CBT has been made by addressing maintaining factors, Salkovskis et al., 1999 observed the following:

> Imagine you have woken in hospital with a broken leg. You have no recollection of how you broke it. There is no need to know the cause of the fracture in order to mend the break. In fact, the leg usually heals itself; what the doctors do is identify and deal with anything which might slow down or prevent the normal healing process. Once you are back on your feet, however, you might want to consider how the leg got broken. It may

> have been a complete accident, so that you stumbled and fell for no obvious reason. However, it might be that you tripped because there is a section of loose stair carpet, so that one day soon it will all happen again. If that's the case, you would want to fix the carpet. Our experience is that, in some cases, there are general and enduring belief factors which may have made the patient prone to developing OCD, and which do not fully change in the course of treatment, and that it can be helpful to identify and deal with these. (p. 1069. Reprinted with permission.)

In describing CBT for mental contamination, Rachman, 2006 noted:

> In order to carry out exposure at the clinic, he brought a selection of contaminated items from his home. One of the items high on the list of contaminants was a sorry-looking credit card that had belonged to his late but definitely unlamented aunt, a person who had humiliated and criticized him throughout his unhappy childhood. Although the aunt had died 15 years earlier, touching the card instantly produced strong feelings of contamination and a need to wash his hands. Moreover, when he was asked simply to form a vivid mental image of his aunt's face, a task that he was reluctant to undertake, comparable feelings of contamination were evoked. The feelings were removed by cleaning his hands with anti-bacterial wipes that he always had available.
>
> This person's experiences of mental contamination reflect a number of features of the phenomenon. The feelings and fear of contamination arose after a lengthy period of domination during his childhood and were revived and intensified in adulthood when he felt betrayed by his partners. The power of the contaminants did not degrade and neither did the memories of the contamination. The feelings of contamination were provoked by direct contact with the person responsible for the violation or any of her belongings, by indirect contacts, and by memories/images without any contacts. Temporary relief from the contamination was achieved by compulsive cleaning. His feelings of contamination had elements of fear and disgust. Most interesting, the emergence of his fear of becoming ill as a result of contamination arose from a sense of violation rather than any contact with potentially harmful substances. (pp. 23–24)

As discussed in earlier chapters, current research indicates that there remain a substantial number of OCD patients who respond only partially, do not sustain gains, or drop out of CBT that focuses exclusively on maintaining factors. Broadening our conceptual and intervention repertoire to encompass schemas may contribute to improved response for some cases, as outlined in the following sections.

The Model in Theory

Given the heterogeneity of OCD symptoms and the status of treatment outcomes that remain applicable at the time of writing this book, Sookman and colleagues proposed a theoretically broad but specific model for conceptualization and intervention planning with OCD. This section is adapted from Sookman et al. (1994) and Sookman and Pinard (1999). The following concepts were proposed as relevant to OCD symptoms: (1) schemas (Beck & Freeman, 1990; Beck, Emery, & Greenberg, 1985; Beck, 1996; Beck & Haigh, 2014); (2) developmental theory (e.g., Piaget, 1960); (3) role of attachment experiences (Bowlby, 1985; Liotti, 1988, 1991); (4) constructivist model of identity structure (Guidano, 1990; Guidano & Liotti, 1985); and (5) metacognitive and appraisal theory (Salkovskis, 1985, 1989; Wells & Mathews, 1994). The figures shown here have been adapted slightly from Sookman et al., 1994.

Figure 10.1 shows the general model that was discussed in Chapter 3. Figure 10.2 elaborates that aspect of the model pertaining to "identity structure" (adapted from Guidano & Liotti, 1985). Cognitive, emotional, and motor schemas are hypothesized to interact at a tacit level (beyond immediate accessibility to awareness) and to influence explicit information processing, emotional retrieval and experience, and behavioral responses. Of course, much normal autonomic information processing is ongoing beyond accessibility to awareness (Beck & Clark, 1997). The CBT theoretical concept of tacit differs in hypothesized structure and content from the psychoanalytic construct of "unconscious." The former is built upon the concept of schemas as defined by Piaget that are transformed through development.

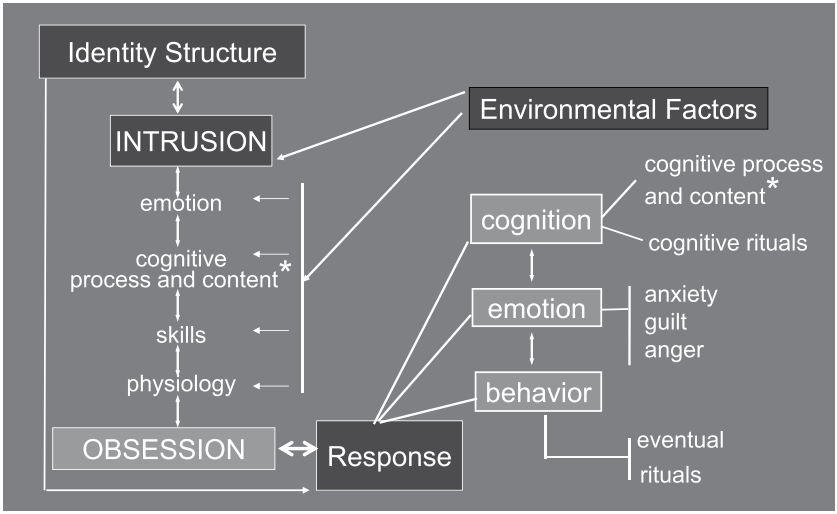

Figure 10.1. Transformation of an intrusion (Adapted from Sookman et al., 1994, p. 179.)

**Cognitive processes and content range from automatic thoughts to high-level information processing.*

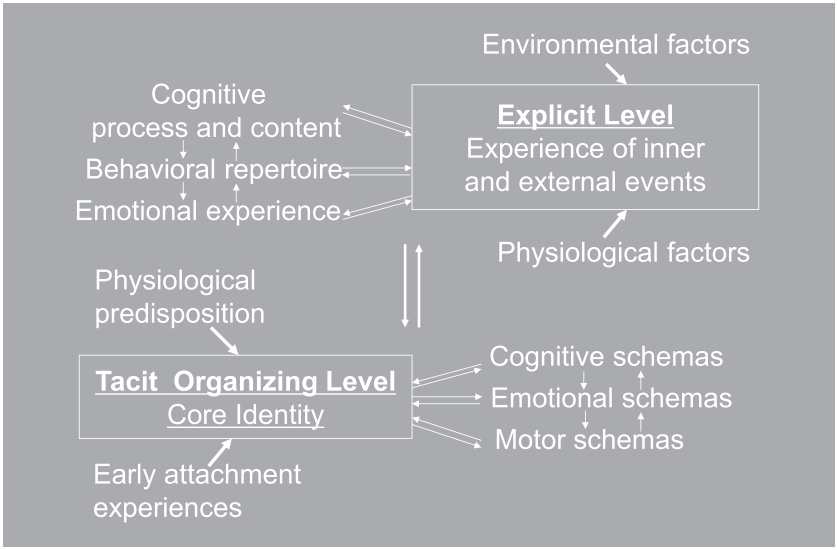

Figure 10.2. Identity structure. (Adapted from Sookman et al., 1994, p. 178.)

In understanding the theoretical construct of schemas and the proposed "tacit" level of information processing and awareness, it is important keep in mind that:

> CBT was originally developed in part to address the limitations in theory, practice, and outcome of earlier existing approaches, most notably the psychoanalytic approach. Historically, there was growing recognition and concern that existing approaches, although theoretically rich and clinically complex, did not reliably result in sufficient symptom change for many disorders and that "insight," even when apparently achieved, did not necessarily correlate with sustained symptom change for many patients. (Sookman, 2015)

Core schemas are hypothesized to develop during attachment and developmental experience and to accommodate throughout the lifespan (e.g., Bowlby, 1985; Piaget, 1960). Schemas that do not accommodate adequately to new experience may contribute to intransigence of dysfunctional patterns (Rosen, 1989; Beck & Freeman, 1990; Safran, 1990a, 1990b). Sookman et al. (1994) hypothesized that vulnerability schemas when activated are a central mechanism underlying emotional experience and appraisals of danger characteristic of several OCD subtypes. The Vulnerability Schemata Scale (VSS; Sookman et al., 2001) was developed to assess the following four vulnerability dimensions characteristic of OCD: (1) perceived vulnerability; (2) difficulty with unpredictability, newness, and change; (3) excessive need for control; and (4) view of/response to strong emotions. This last subscale assesses beliefs about strong feelings and one's capacity to tolerate and cope with these in oneself and others (e.g., "Strong feelings are dangerous" or "I cannot cope with strong feelings"). The VSS validation study indicated that, as predicted, items on the vulnerability, unpredictability, and control subscales were significantly more strongly endorsed by OCD patients compared with patients with anxiety disorders and nonpsychiatric controls. Perceived difficulty to cope with strong emotions was found to be more characteristic of both OCD and anxiety disorders compared with normals. More recently, Voderholzer et al. (2014) also reported elevated vulnerability schemas in OCD.

Rachman (2006) noted with regard to contamination fears:

> The illusion of elevated personal vulnerability has several components. The first is an extreme over-estimation of the probability that contact with a perceived contaminant will produce harmful effects for me. The second component, an extreme over-estimation of the seriousness of the consequences of the contamination, is contributory to the fear. An extreme over-estimation of the ease of transmission of contamination to one's self or others is contributory to the degree and extent of the fear. (p. 82)

The specialized treatment approach for OCD described in this chapter is delivered at the specialized clinic for OCD and Related Disorders at the McGill University Health Centre in Montreal that since 1987 accepts OCD patients of all ages (children to seniors) regardless of comorbidity or illness severity. Psychiatric consultation and pharmacological intervention are available as needed. A treatment overview will be presented next followed by illustration of this integrative approach.

In our approach, Beckian cognitive therapy (e.g., Beck, Emery, & Greenberg, 1985; J. Beck, 1995; A.T. Beck, 1996) is administered prior to and during ERP and behavioral experiments and in homework assignments for virtually all patients. Cognitive therapy includes a three-step protocol that includes strategies to tolerate, reappraise, and distance from intrusive thoughts, distress, and other symptom-related experiences that are taught in sessions and practiced during behavioral interventions and during homework. Evidence-based strategies for subtype characteristics are applied as described throughout this volume. Imaginal (as appropriate) and in vivo practice of strategies to label, modulate, and reappraise strong feelings (and skills to appropriately express these) precede and are combined with behavioral experiments and ERP (see Sookman et al., 1994; Sookman & Pinard, 1999, for illustrations). Subtype characteristics are specifically targeted: for example, "not just right" experience and intolerance/misappraisal of distress for washers who "just can't stand the feeling," for persons with mental contamination, and for individuals with symmetry, ordering, and arranging who do not report elevated beliefs on cognitive measures but are distressed by a sense of "incompleteness" (Taylor et al., 2006).

The primary focus of cognitive therapy in this approach is not necessarily cognitive dysfunction. The (hypothesized) inseparable components of cognitive–emotional–interpersonal–behavioral (Beck, 1996; Beck & Haigh, 2014) schemas are targeted. Schemas are addressed if they appear related to intransigence of symptoms, for about 50% of cases seen in the clinic. These are considered if the patient's participation in ERP or behavioral experiments is not complete and/or if avoidance of inner experience or metacognitive dysfunction is inadequately resolved. Inclusion of these strategies is also contingent on attachment and developmental experiences reported.

We generally choose graduated exposure and complete response prevention. However, when rapid improvement is urgent (e.g., a parent whose OCD interferes with child care) or prior graduated approaches have been ineffective, flooding to most-feared stimuli may be implemented with patient collaboration and consent. As was illustrated when discussing contamination fears, an advantage of flooding for some disabled patients with pervasive rituals may be speed of habituation, belief change, and self-efficacy. Complete response prevention procedure has the advantage of preempting the patient's struggle to resist rituals following exposure, thereby reducing distress and suffering. Therapist-assisted in vivo ERP and behavioral experiments are administered in patients' environments (home, work) when response to office-based treatment is insufficient. Adherence to homework is regularly assessed. Severely ill patients are offered intensive naturalistic CBT. Hospitalization has been made available for intensive specialized CBT for approximately 3 months, with 2- to 4-hour sessions four times weekly, followed by twice weekly outpatient treatment for at least 6 months. Significant others participate regularly in selected sessions to reduce accommodation to symptoms, with the agreement and collaboration of the patient and congruent with the patient's progress. Sessions with family/significant others involve education, modeling of behavioral interventions, gradual withdrawal of inappropriate reassurance, and fostering of autonomous functioning. Significant others are not included if they are deemed too antagonistic or dysfunctional to participate or if this is considered to be inappropriate—for example, in the case of a young adult struggling with autonomy, responding well, who requests that parents not attend

sessions. Varied skills strategies for emotional regulation, decision making, problem solving, social and vocational skills, etc., are administered to help ameliorate common multisphere skills deficits that result from disabling symptoms. Treatment decisions are of course also determined by comorbid disorders and personality factors. For example, flooding procedures are generally inappropriate for individuals with comorbid psychotic disorders or poor premorbid functioning (e.g., low resilience and coping skills).

Relapse prevention and generalization strategies are emphasized. These include therapist and family fading, anticipation of triggers, and imaginal rehearsal of coping under stress. Guidelines to maintain progress under stress are discussed. It is recommended that the patient continue to engage in adaptive strategies for intrusions and urges to ritualize under stress with cognitive strategies and self-administered ERP. Sookman and colleagues developed the technique of "corrective cognitive and emotional strategic processing" (Sookman & Pinard, 2007), a preventative information processing strategy that aims to generalize change and to protect against relapse throughout and following treatment, illustrated with several cases (e.g., Michaela, treatment of contamination, Chapter 7 this volume).

Finally, treatment is not time limited and is based on clinical need. Duration of treatment ranges from 6 weeks to 2 years, with booster sessions provided as needed. Severely ill patients who receive schema-based interventions may continue treatment for 2 years or more.

The Model in Practice: Schema-based Assessment and Treatment Interventions

In this section the Sookman et al. approach is summarized with illustrations of schema-based strategies. Treatment starts with elements perceived as threatening that are readily accessible to awareness: *feelings*, *sensations*, *images*, *urges*, *impulses*, *intrusions*, and *thoughts*. Only some patients initially recognize associations among inner experience, behavior, and core aspects such as self-image. For example, Michael was a 25-year-old orthodox Jewish student who spent 5 hours daily on checking rituals. He reported (confirmed by therapists) being unable to participate in response

prevention in two previous cognitive therapy and ERP/behavioral experiments attempts that lasted 2 years. He stated during an initial session:

> I have many intrusions I will miss a signal that someone else is in danger and I will not act fast enough to save them. Last week I saw that a road sign about a sharp turn ahead had fallen off. The bus was going so fast that by the time I rushed to the front and spoke to the driver he did not know which road I referred to. So I could not report it. I had images all night of someone dying because of me and felt I am basically a bad person who does not care enough about others. I can only feel good about myself if I feel I have done enough checking to make sure others are safe. I'm afraid I will never be able to get over the guilt and these feelings will interfere long-term with my being happy. (Sookman & Steketee 2010, p. 57)

Here, Michael initially reported feeling that he is a *bad person* unless he performs his rituals. The feared consequence he expressed with insight was that he had no right to happiness because of his own feelings of guilt. However, this insight did not improve collaboration with previous treatments and he remained risk aversive. During treatment at our clinic, Michael and the therapist identified aspects that appeared less accessible and that he did not initially report. Access to these variables may be essential to modify patients' strategic processing of distressing events. As Sookman and Pinard (2007) noted:

> Patients are typically less aware of: (a) the role of their myriad emotional, cognitive, and behavioral responses to inner and external events in perpetuating symptoms; (b) the influence of core aspects, such as personal values (Rachman, 1998), on their responses to specific events; and (c) the impact of past experience on current functioning. The downward arrow technique (Beck et al., 1985) to identify core beliefs in OCD has been described elsewhere (e.g., Freeston et al., 1997; Wilhelm & Steketee, 2006). The aim of the downward arrow in this approach is to reach a level of belief that is relatively undissociated from emotion, that is, at the implicational level (Teasdale & Barnard, 1993). Regardless of content, the therapist assesses and targets dysfunctional emotional beliefs such as "*I don't believe it's true, but I feel it's true*." (pp. 101–102)

As Teasdale (1997) has noted:

> The simple assumption that certain types of cognition are the antecedents to emotional reactions has to be elaborated to include recognition of the fact that those same cognitions may be so powerfully influenced by affective state that cognition often appears to be a consequence of emotional state . . . We can get round such difficulties by suggesting that there is a reciprocal relationship between cognition and emotion. (p. 67)

Example of Downward Arrow Technique

P. "I'm having thoughts all the time of strangling my baby."
T. "What do you make of this?"
P. "I love my baby. If I have thoughts of hurting him, a helpless baby, my son, that means I might do it."
T. "When you have these thoughts what do you feel you have to do?"
P. "I have to go into his room every 5 minutes to make sure he's OK, that his shirt is not too tight, that he's lying in a position where he won't stop breathing. I can't sleep at night, I have to keep getting up to check."
T. "Are you're saying that just having this thought, that is so abhorrent to you, means to you that you are more likely to act on it?"
P. "Yes! I try so hard to get the thought out of my mind. I try to change the thought to something else. But the more I try to get rid of these thoughts the more they occur to me. I'm afraid I'm losing my mind and I might lose control of my behavior."
T. "What do these thoughts mean to you?"
P. "Obviously I'm a bad mother and wife. No decent loving mother thinks of strangling her baby. I can't live with these thoughts."
T. "Are you saying these thoughts mean something about your view of yourself?"
P. "I am a bad person who may kill her child." (*patient cries*)
T. "Based on what we've talked about, how much do you believe this now? These thoughts are abhorrent to you. You are a kind and gentle woman who is taking good care of your baby. You are giving your thoughts a meaning they don't have. . . . "
P. (*interrupts*) "I understand with my head that I'm tired, very concerned about being a good mother, and that these thoughts are just an expression of what I am most afraid of but would never do. I know what strategies I'm supposed to use. I understand that being a mother for the first time is stressful. You have told

me other mothers have all kinds of thoughts too but appraise these differently. I don't believe it's true but in the heat of the moment I *feel it might be true* and I can't take the chance. I have to protect my baby and check. I feel that because I have these thoughts I am a deeply bad person. I don't deserve to feel happy with my child or my husband."

In the next step, schemas are linked to symptoms. The following sequence illustrates maladaptive information processing that would be communicated to the patient (inserting his/her idiosyncratic content):

> Preexisting dysfunctional cognitive and emotional schemas (e.g., vulnerability schemas) influence autonomic and strategic processing of events → specific inner and external events are experienced/appraised as dangerous → strong feelings of distress, urge to act to restore predictable feelings of safety and comfort, fear of loss of control →hyperattention, vigilance, thoughts about thoughts, thought suppression, misappraisal of and catastrophizing feelings, cognitive rituals, behavioral rituals, reassurance seeking, and avoidance →appraisals and beliefs about (inevitable) failure of dysfunctional strategies →perceived confirmation of dysfunctional core schemas →escalating distress and symptoms. (Adapted from Sookman & Pinard, 2007, pp. 101–102)

Figures 10.3 and 10.4 illustrate another example of downward arrow followed by upward arrow technique. Upward arrow technique, labelled by Sookman & Pinard (1999), is used to link schemas and related developmental experiences with current symptoms and related appraisals (see case illustrations later in this chapter). The therapist discusses potential effects of attachment and developmental experiences on current functioning in order to further understand and reduce intransigent entrenched patterns. An aim is to help the person to express and to reappraise symptom relevant schemas and to risk exposure to situations that activate these. It is recommended that patients engage in behavioral experiments with the aim of experiencing feared situations "with new eyes." Importantly, as is often needed, new skills are taught and practiced. Graduated behavioral experiments are designed to disconfirm maladaptive emotional responses and core beliefs (flooding is not recommended here).

P: I have to check I haven't made any mistakes by making lists, or else I feel anxious, unsure of myself.

T: What experiences have you had in the past where you felt unsure of yourself?

P: My father was a perfectionist, very critical of me. The only way I could earn his respect was by getting only A's in school, by not making mistakes. Never make a fool of yourself in front of others!

T: How did this affect you?

P: Even in high school I used to check my homework over and over to make sure there were no mistakes. Then I'd make review lists in my head.

T: How did you feel if your father criticized you for making a mistake?

P: Nothing I did was good enough for him, even though I tried.

T: What did that mean about you as a person?

P: I'm just not good enough …I am an inferior person.

T: Inferior in what way?

P: Like something serious is missing in me, like basically I am a inferior person (patient cries).

Figure 10.3. Downward arrow.

P: You mean I could try not to list things as much? (skeptical)

T: Would you like to risk some imperfection this week, see what you feel, how you can cope, and how others respond?

P. I try to be perfect, so no one can find fault with me.

T: How do you feel these past experiences, and the meaning they had to you, are affecting you now?

P. I'd like to feel it's not my fault, not my defect. My father had low self-esteem himself.

T. We could try to reappraise your experiences with your parents, like we've done for more current events. As a child, you obviously could not do this.

P. No, not really, this is the way I've always seen it.

T: Can you think of any other way to understand your father's critical behavior toward you?

Figure 10.4. Upward arrow.

Returning to Michael's case, previously intransigent feelings of guilt and core beliefs about badness were addressed by helping him to *emotionally* differentiate between what he experienced during attachment experiences compared with normal standards for interpersonal responsibility and ethics. He reported being able to risk disregarding, rather than acting on, urges to repeatedly check. He reappraised his feelings of guilt as learned from his relationship with his father that he could now disregard in the present. A series of planned behavioral experiments were created to consolidate his new appraisals combined with response prevention for hypervigilance and cognitive and behavioral checking:

> My father was more particular even than our orthodox rabbi about the way I observed our religion. If I made any mistakes when I would daven (pray) he asked me to repeat sentences over many times. He told me it was not good for my spiritual well-being and happiness to be sloppy. What got to me was the unhappy part, I felt like that when he was around. Frankly, I didn't care then about how perfectly I recited prayers. But I guess I cared about my father's opinion. . . . I swallowed it hook, line, and sinker. Now I am obsessed that if I am sloppy with people I am doomed to unhappiness. Another way to see this is my father was overly rigid . . . but I ended up feeling I am basically a bad person. To reassure myself I'm not, I have to check out and act on every imaginable threat to everyone, or else I do not deserve happiness. But maybe my standard of sloppy is a normal person's standard of responsible and my father's standards were unreasonable. (Sookman & Steketee, 2010, p. 59)

As described by Sookman et al. (1994, p. 90), the therapist tries to foster "*relational affective relearning*" (Sookman et al., 1994, p. 90). This aim has been described in other theoretical frames (Greenberg & Safran, 1987; Safran, 1990a, 1990b). The therapist makes use of spontaneous emotionally meaningful interpersonal "hot moments" to disconfirm dysfunctional perceptions, to link these to past experience, and to current dysfunctional patterns. The therapist offers reappraisals and models normal risk taking, anxiety management, and skills as appropriate.

The next case illustration is from an early session with Sally, age 21, who presented with perfectionism and disabling ordering rituals associated with intense distress if things are not "just right." She lived with her mother and demanded unwavering sameness in her environment. The need for cleanliness and checking rituals pertained to need for precise predictable order. Sally reported that she experienced "panic attacks" of crying and screaming at provocations as insignificant as a few drops of water left accidentally on the kitchen counter. On her arrival home from school each day she engaged in a 2-hour review in the home to ensure her mother had not left anything out of place. Sally woke her mother in the middle of the night if something, however small, was amiss in the house. Her mother attended the initial appointment at Sally's request and confirmed that she accommodated to all Sally's demands. Sally reported that with several close friends small deviations from routine made her feel "put down" (e.g., change in time of a meeting by half hour). She concealed her reactions in order to preserve the friendship but reported that she obsessed for hours after the event about "what this means about my friends' attitude." Sally's initial attitude to the therapist appeared watchful and distrustful. During the second session, Sally suddenly reported that she felt intensely distressed because one of the therapist's hand movements provoked strong feelings of being "devalued." Sally began to cry and stated: "I can't do this . . . I left three other therapists because of this. . . . I won't be coming back." The therapist suggested to Sally that she remain and expressed hope they could understand this together. The therapist asked Sally when she first recalled a similar feeling. Sally reported that at the time her OCD began (age 11) her mother was diagnosed with uterine cancer and underwent surgery. At the same time, her father began drinking. Both parents were perceived as unpredictably unavailable. Sally recalled feeling "frightened, ignored, angry . . . alone . . . not an important person . . . no one noticed me . . . everything was out of control and unpredictable." Her behavioral controls of her environment and her mother began shortly after mother returned from the hospital. Sally demanded her mother spend increasing time (3 hours daily) arranging the house "just so" lest Sally experience panic and "tantrums."

The next few sessions were devoted to reappraising these painful past experiences and discussing their relation to her reaction to the therapist

as well as to symptoms. Sally was able to reappraise her fear that the therapist would be unpredictable, that minor hand motions signified devaluation of Sally as a person, and that she would not be able to cope with her own feelings. Sally discovered that she felt not only fear but also anger at any disorder that "reminds me of the emotional disorder during that period of my life . . . I never learned to cope with. . . . I never want to feel again." She learned in cognitive therapy and behavioral experiments to differentiate between past and present experiences. As treatment progressed Sally said she could increasingly envision that with further skills and practice she could learn to (and wished to) cope flexibly with normal unpredictability and changes in "sameness. " In a series of behavioral experiments Sally was able to allow and to tolerate progressively more normal "disorder" and "unpredictability" in her home, with her mother, and with friends.

Outcome of This Approach

Sookman, Dalfen, Annable, & Pinard (2003) reported outcome data on OCD symptoms, depression, and beliefs using this schema-based approach with a sample of 25 CBT-resistant OCD patients including all symptom subtypes. Previous cognitive therapy and ERP had lasted more than 2 years. According to patient and therapist reports, prior therapy had included cognitive therapy and ERP in once weekly office sessions. In this study, individual outpatient sessions were administered one or two times weekly for an average of nearly 10 months and included the interventions described earlier. Of the 25 patients, 20 patients showed clinically significant improvement in OCD symptoms and depression (Jacobson & Truax, 1991).

As shown in Figure 10.5, overall mean Y-BOCS score improved from 23.2 to 11.9. More importantly, 10 patients were recovered (Y-BOCS score < 7) following treatment. Another 10 reported mild symptoms (Y-BOCS < 16), and five remained moderately ill.

As shown in Figure 10.6, dysfunctional beliefs at three levels were assessed: appraisals on the III, assumptions on the OBQ-87 (OCCWG, 2003), and core beliefs on the VSS (Sookman et al., 2001). Dysfunctional beliefs reliably improved for responders and did not change for

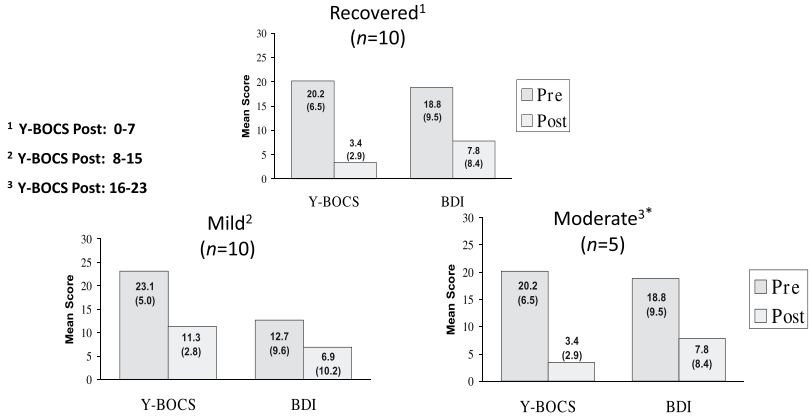

Figure 10.5. Response to treatment based on Y-BOCS at posttreatment (N = 25).

Source: Sookman et al. (2003)

** Recovered vs. moderate Y-BOCS pre: $p < .05$*

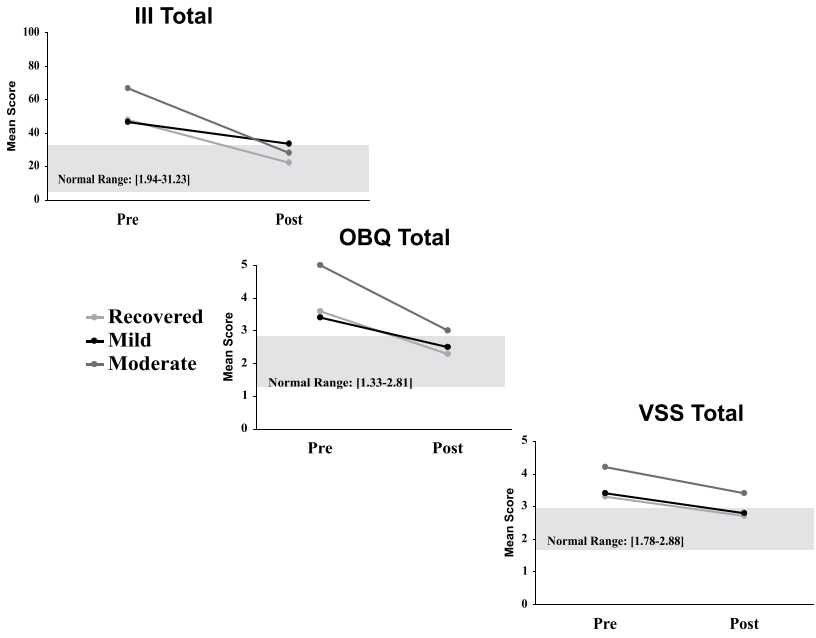

Figure 10.6. Change in dysfunctional beliefs based on Y-BOCS at posttreatment.

Source: Sookman et al. (2003)

nonresponders. Only symptomatically recovered patients showed reductions in dysfunctional beliefs at all three levels to within normal range at posttreatment. The authors attributed these results for previously resistant samples to the specificity of this CBT approach, such as attention to subtype characteristics in evidence-based CBT as well as inclusion of work on schemas hypothesized to be relevant to patients' resistance to change. Some patients who previously did not participate in ERP did so in these trials. The important question of long-term maintenance of change is currently under study in a 5-year follow-up. The following section presents case illustrations of this approach.

Case Illustrations

Case # 1

Amelia was a 37-year-old married woman, mother of four children, referred from the United States after several years of unsuccessful psychotherapy and 2 years of weekly CBT had failed to ameliorate her presenting symptoms. Amelia and her husband, a successful physician, reported that Amelia had a 15-year history of OCD and more recently a 5-year history of shoplifting. Although wealthy, Amelia seldom purchased anything for herself. She reported the sequence as compulsive rather than impulsive: "I spend hours obsessing about what I want to steal. I always plan carefully. I have a wide range of stores all upper end. I take the maximum number of things into the change room. I remove the tags, put the items in my large purse, wait until the person in front is busy, put some of the items back, and try to walk out of the store without paying." Amelia had been caught by the store security and charged numerous times. Amelia reported that although she initially made an effort not to be caught, more recently she took fewer precautions and was caught repeatedly. After several court appearances in which her sentence was suspended contingent on therapy, Amelia received a final warning that the next time she was caught shoplifting she would be sentenced to a substantial jail term. Amelia reported moderately severe OCD symptoms (Y-BOCS = 28) that predated the shoplifting by about a decade. She described pervasive need for symmetry and order, especially in her home. She reported spending many hours daily doing housework,

refusing the help of a cleaning lady. Beds had to be made "without a crease left," countertops and floors had to be "spotless," and "everything has its place." Amelia described spending hours rearranging decorative items in her large luxurious home. Despite her OCD symptoms, Amelia described an active social life and "good" relationship with her husband and children prior to the onset of the shoplifting. For several years she had become increasing socially isolated. Amelia reported great difficulty spending time with her youngest child, Cindy (age 5), to the point that a nanny had to be brought into the home to care for this child.

During the first several sessions Amelia's attitude toward the therapist appeared disdainful and devaluing. She arrived to the second appointment with a large suitcase and piled the contents on the therapist's desk, stating: "Here are the towels, lamp, and the picture I have stolen from my hotel room today. I don't know what makes you think you can help me as I've had the best therapists in our home city. I really don't want to stop OCD or shoplifting and I doubt you can change my mind. I'm here only because previous therapy didn't help. You're a specialist and I guess I don't want to go to jail. I've embarrassed my entire family with my behavior but I doubt I'll stop. This trip to Montreal is most likely a waste of time." Amelia sounded angry, but she denied feeling angry. When I asked what it meant to Amelia to show me these things she stated: "I want you to know how hopeless it is." I asked her to return the stolen items (she agreed to do so).

Amelia gave the following history of her OCD and shoplifting. She experienced a privileged childhood as an only child; her father was a wealthy successful physician and her mother was a housewife. Since she was a little girl mother emphasized perfectionism: "My mother told me that the most important goal for a girl was to learn all the social graces, be sure to remain a virgin until marriage, and strive for perfection as a wife and mother." Amelia attended private girls' schools as well as finishing school. Her mother enrolled her in cooking and sewing classes, though Amelia would have preferred art. Amelia met her husband, now a prominent surgeon, at a party in her parents' home. They dated for a year: "I never felt like this about anyone. I loved him so much." The couple married and had three children. Amelia described her relationship with her husband as follows: "He's a very busy and important doctor. I don't bother him

about household matters. I make sure every dinner with his colleagues is 'unmatched' in our social circle. It takes me days to think about, plan, and cook when we entertain. Every piece of silver and every embroidered napkin is perfectly placed. Robert always says how proud of me he is." When the therapist asked Amelia if she expresses her feelings to her husband, such as joy, sadness, anger, Amelia replied disdainfully: "I share the good things, I keep everything else to myself. I'm a good wife." Amelia's husband Robert confirmed this behavior and added that in order not to "burden" Amelia he also keeps feelings perceived as negatively valenced to himself.

Amelia's shoplifting behaviors began shortly following the death of her fourth child from Tay-Sachs disease (5 years prior to the initial assessment with me). She had given birth to twins, David and Cindy. Amelia described the events surrounding the diagnosis and death of her son David with a shocking absence of feeling. As the therapist listening I felt very sad in response to the events, but Amelia sounded as if she were recounting what she planned to prepare for a particularly boring dinner. The following is a segment from the third session:

T: "This tragedy must have been a very painful event for you and Robert. How did you feel?"

A. "I felt numb . . . I felt nothing."

T. "Did you cry?"

A. "No, I never cried."

T. "What did you feel?"

A. "Nothing."

T. "What do you make of this, that you say you did not have feelings about the tragic loss of your child? It would be normal to have very strong feelings."

A. "I was in shock and I did not feel anything. I went through the motions, the funeral, the speeches, I did the right things, I suppose I looked sad, but the truth is I felt nothing. I was glad when all the people went home."

T. "Did you mourn?"

A. "Probably not, and I don't want to."

T. "Are you afraid of what you might feel if you mourn?"

A. "I've already told you I feel nothing about this." (*sounds annoyed*)

T. "What about Robert, and your children, how did they react to David's death?"

A. "Robert was very upset. He cried at the funeral and for a few days after and we hugged a lot. He asked me if I wanted to talk about David. I told him no. I put

all the pictures of David away and put him out of my mind. But after that I just couldn't spend any time with Cindy anymore. I started to feel revulsion to her. I couldn't touch her anymore. We eventually hired a nanny to take care of her. Cindy cried a lot at first, but she seems OK now. I'm sorry about this as I'm her mother but I can't help it. Don't ask me why, I don't know. My previous therapist said Cindy reminds me of David, but I don't feel it. I'm very close to my other children and I do everything for them . . . I would do anything for them." *(Amelia elaborates at length, and then speaks about numerous social events in her circle of friends.)* "Robert works longer hours than he used to but this is OK with me."

T. "Do you feel there is any connection between David's death and the shoplifting you started soon afterward? You also mentioned to me that your OCD symptoms became a lot worse after his death?"

A. "Look, every therapist has asked me that. They said they thought so. I feel down and empty, I plan to steal, I get a high for a few hours after, it doesn't last. I usually give what I steal to charity. I get a good feeling when everything in my home is perfect, I feel empty when it isn't, and I *want* to keep things perfect."

T. "What do you feel like when you feel down or empty?"

A. "I don't know, I have everything I want . . . I have nothing to say about this."

B. "Can you tell me about your previous therapies, what you talked about, what you felt."

A. "I had about a year of CBT for OCD really for Richard and the kids more than for me before I got pregnant with David and Cindy. But I didn't want therapy. As I already said, I enjoy having things perfect. I get a feeling of fulfillment when my pictures, my jewelry, everything really are lined up just the way I want. I feel empty and incomplete if anything is out of place and I never really wanted to work on it. I feel it's who I am. After the death Richard took me to see a friend of a friend who is a psychoanalyst. I saw him twice a week for two years. He told me I needed 'to get in touch with my feelings.' He asked me to talk about David's illness and death, and I did many times. I felt nothing when I talked about it and I found the therapy had no effect really. He asked many questions, sometimes I didn't even bother to answer and just stayed quiet or after the sessions I would shoplift. *You can't get blood from a stone*. I can say what happened but I don't feel anything. I know it's unusual but that's the way it is. I went to therapy because my husband wanted me to but he could also see it didn't help."

Amelia reported that she also underwent CBT for shoplifting once weekly for 11 months. She (and the therapist) described imaginal rehearsal to triggers urges to steal, graduated exposure to triggers and stores in which

the urge to steal arose, and response prevention instructions, including therapist in vivo modeling and assistance. Amelia stated: "I often stole when the therapist was with me but not watching . . . it had no effect."

In summary, after four sessions, I was faced with a patient who said that she was entering therapy for shoplifting as an alternative to going to jail, had placed stolen items on my desk in the second session, and had suffered from long-standing OCD she stated she did not wish to change. Most striking of course was the reported absence of experience or expression of normal feelings of grief or anger about the death of David, or indeed about anything else. Amelia had obviously not mourned the loss of her child despite previous therapy with a well-known psychiatrist who had attempted to make this the focus of her prior psychotherapy. The only apparent feelings expressed by Amelia during sessions were devaluing expressions of annoyance at me for asking the "same old questions." I considered declining to treat her because I felt significant doubt that I could help her. I consulted about this case with two colleagues prior to developing a plan. One senior colleague strongly advised another trial of CBT for shoplifting to try to avert a jail sentence as this was the requested mandate of therapy. The second colleague suggested that I try to help Amelia with her feelings, but he said that he could not suggest how given the prior therapeutic attempts and that in any case the patient might not accept this goal.

I read extensively about Tay-Sachs disease to try to learn about what Amelia had experienced. One crucial point Amelia communicated is that she had cared for David at home, despite being advised that the child's deterioration would be extremely painful for the parent (she was advised that care could be delivered at home under medical supervision). On further questioning I learned that David had died at home in Amelia's arms while they was alone.

My initial conceptualization and treatment recommendation based on limited information follows: I told Amelia that I thought the tragedy she had lived was related to serious avoidance of mothering Cindy, in striking comparison to her devotion to her other children; increased emotional distance and further reduction of emotional communication with Robert; exacerbation of OCD symptoms; and subsequent onset of shoplifting. I told Amelia this hypothesis was based on evidence of

striking avoidance of feelings that would normally be expected to be very intense during and following such a loss. Using Amelia's metaphor of "you can't get blood from a rock," I said I thought there was a tidal wave of blood locked in the rock inside her that needed to be released and dealt with in order to get her life back. I informed her there was a protocol in CBT that might help her to access her feelings that "just talking" had not achieved. I stated that in my opinion working on the shoplifting alone would be ineffective given her ongoing emotional avoidance, and further that shoplifting might be an ongoing expression of feelings she was avoiding. I informed Amelia that if the intervention was successful a risk was that she might experience very intense feelings of grief and rage, etc. I further expressed that despite Amelia's long-standing OCD her descriptions of her prior functioning indicated that she had considerable resilience, but that I could not guarantee the result—there was a chance she might feel worse. Amelia expressed doubt that anything would have any effect but she said that she was willing to take the risks.

I proposed imaginal flooding to the detailed events following David's birth including his death in her arms. As a first step I asked Amelia to write down the events as they occurred in as much detail as possible omitting no detail: her feelings at this child's birth, the first moments she noticed illness, the delay in diagnosis, every symptom David experienced, Amelia's and the family's response, what exactly occurred when David died in her arms. I asked Amelia if she thought it would upset her to write the story, and she said that it would not.

Amelia arrived to the next session with a five-page story. Where details appeared to be missing or insufficiently graphic we added components together. Amelia reported that she had "felt nothing" writing the story.

She predicted the session would have "no effect." The protocol for the first imaginal exposure consisted of a prolonged 90-minute session in which Amelia was asked to close her eyes and to imagine every detail in the story, as if it was actually occurring, while I read the story to her. I read with much genuine feeling as it was indeed a heartbreaking story. Amelia described the joy and pride she had felt at the birth of her beautiful healthy twins. "I was a good mother, a success in every way as a woman." She described the pride with which she pushed the double stroller in

the park, and enjoyed imagining the "envy" of other woman. At about 4 months Amelia began to notice signs that something was wrong with David. Robert called her a "worrier," and the pediatrician assured her all was well. With growing doubt and anxiety Amelia observed David's symptoms progressing. He became increasingly unresponsive, did not consistently grip her fingers or make eye contact, did not eat well, and could not be comforted. Amelia insisted on taking David to a specialist who ordered genetic testing. Amelia described the pain of waiting for the result, knowing what positive for Tay-Sachs would mean. The test showed that Amelia was a carrier, and David was diagnosed with rapidly progressing Tay-Sachs. Amelia was determined to care for him at home, with guidance and visits from nurses and frequent visits from the physician. David's medical deterioration was described in the story in detail, including neurological symptoms, seizures, and difficulty breathing. Amelia took David to the hospital often and was told nothing further medically could be done. David died in her arms during a seizure, unable to breathe. In reading this sorrowful story I felt very sad and close to tears. Amelia remained silent. I read her the story four times in the first session. At the end of the first session Amelia stated: "I am trying not to feel" rather than "I feel nothing." During the second session I reread the story to Amelia twice, with feeling, and further emphasized that she make every effort to imagine every detail as if it were really happening: the feel of David's body, the sound of his struggle to breathe. Amelia began to sob abruptly and she cried throughout the remaining hour of the session, shaking her head to indicate that she could not speak (I stopped reading when she began to cry). I offered to see her later that day but she refused, keeping her appointment the next day. Reading the story was not repeated. During the next 12 sessions Amelia spoke at length, crying often, about the events surrounding the birth and death of David and how unbearable the pain was, with an attitude toward the therapist that was dramatically improved. For the first time Amelia expressed the wish for help. In summary, with further exploration, we were able to collaboratively construct the following emotionally meaningful conceptualization: Amelia said that she felt entirely responsible for the death of her child because "I gave him the TS gene." Her husband's responsibility (he was also a carrier) was experienced as "irrelevant." Amelia stated:

"I killed my son." With much feeling, she spoke about feeling unbearable guilt and shame at this death. Being near Cindy was unbearable because her presence threatened to elicit these feelings. However, Amelia also felt intense rage at the loss of David: "My gem was stolen from me." Amelia conceptualized her shoplifting as follows: "I deserve to be caught and punished because I'm a bad person" and at the same time "I have a right to take what is not mine because David was stolen from me." She conceptualized her long-standing symmetry/ordering OCD as follows: "Being a good mother, wife, and homemaker means everything to me—since I was a little girl I believed this was a 'woman's worth.' Good wives keep everything perfect. I feel good about myself and complete when I order things; I feel incomplete if I don't." Amelia reported a long-standing history of keeping her feelings from Robert because "good wives don't burden their husband" (repeating what her own mother had done) that likely may have also been an OCD-maintaining factor.

The next 25 sessions, conducted three times weekly, focused concurrently on Amelia's appraisals and excessive sense of responsibility for David's death; her relationship with Robert, Cindy, and her other children; symptoms of OCD; and shoplifting. Varied interventions included cognitive therapy, behavioral experiments and RP at stores in Montreal, RP for OCD (she kept her belongings perfect even when travelling), learning how to buy and do things for herself, and emotional expression skills. Several sessions were held with Robert, who with much feeling said that he had longed for Amelia's emotional expression. He wished to communicate his feelings to her, but that he had "mourned David alone to spare Amelia." Amelia went home to try to generalize her improvement. As had been preplanned during sessions, Amelia reported that she approached, hugged, and spent a great deal of time with Cindy as well as her other children; disordered her home according to a protocol we had agreed upon that emphasized unpredictability and imperfection; and visited every store in which she had stolen leaving either with nothing or with an appropriate purchase. She practiced giving and receiving appropriate emotional expression with Robert and her children. She and Robert visited the cemetery where David was buried for the first time since David's funeral. Amelia returned to Montreal for an additional eight sessions, with several subsequent boosters by phone. At 10-year follow-up Amelia

and Robert confirmed there had not been a single recurrence of shoplifting and that Amelia was "not interested in symmetry." Amelia and Robert reported that she has not received any additional therapy. Her Y-BOCS at posttreatment was 10 and at follow-up was 6. The relationship with Robert was described as much improved. Amelia (and Robert) reported that Amelia was "as close to Cindy as to my other children." I recommended that Cindy be assessed and the parents reported that Cindy had received a trial of CBT and time-limited low-dose SSRI for pediatric OCD and depression (checking and washing; crying spells during which Cindy talked about her mother's unavailability and death of her brother).

Case # 2[1]

This case illustrates the use of schema-based conceptualization and interventions to prevent immediate dropout from specialized CBT. Sara was a 60-year-old woman who came for treatment saying she had suffered from unremitting OCD since age 16 but had never sought help. She said, "My 10-year-old grandson is copying some of my rituals, so I have to get help to make sure this stops. But I doubt you can help me." Her pretreatment Y-BOCS score was moderately severe at 28. Scores on all OBQ-87 subscales (OCCWG, 2003) were elevated and within the OCD range, especially over-importance and control of thoughts. Her endorsement of core beliefs on the VSS (Sookman et al., 2001) was also in the OCD range, especially on Perceived Vulnerability, Difficulty With Unpredictability, and View of/Response to Strong Affect subscales. Sara's rituals consisted of repeating virtually every daily activity, from washing dishes to dusting and dressing. She had difficulty going from one room to another in her apartment, particularly stepping over the threshold from inside to outside her home. She said her rituals were virtually constant, approximately 6 hours daily. When asked about presence of obsessions in the first session, Sara replied: "Oh yes, I have the same bad thought all day long. It's why I do my rituals, to prevent what I think about from happening." When asked about the content of her thought, Sara replied, "I can't tell you because this would make it happen." She reported no other obsessions. Sara said she performed each episode of rituals until the obsessive thought left her mind and she felt safe. Sara said that she

had not previously sought treatment because she believed she could not be helped if she could not disclose her fear. She expressed the following beliefs, in response to specific questioning: "If I tell, it will happen. If it happens it will be my fault. If that happens I will feel overwhelmed with anxiety and guilt. I would never be able to recover. If things are harder for me, they are easier for others." The therapist asked whom the patient felt she was protecting from harm by ritualizing; the patient stated that she was protecting many people, but most of all her three sons. The therapist suggested fears typical in OCD, including illness or death. Sara replied: "Yes, it's suffering and death I'm scared of, but I can't say more."

Following further assessment in the second session (see history later in this chapter), a variety of standard cognitive therapy techniques described by Beck, Freeston, Rachman, and Salkovskis were directed at the cognitive processes Sara had disclosed that provoked rituals: particularly thought-action fusion/magical thinking, emotional reasoning, excessive responsibility, and possibly overestimation of threat. Sara's response was: "But what I'm scared of could actually happen. No one would want it." The therapist tried to help Sara to reappraise her belief that simply telling about the event she feared (however realistically horrific), or stopping rituals, could cause the event to occur. Other interventions included estimation of probabilities, pie chart for responsibility, transfer of responsibility, and strategies to cope with distress. Rather than targeting intolerance of uncertainty, the therapist explicitly stated there was no danger in simply disclosing a thought—and thus the outcome Sara feared was impossible. These interventions were ineffective. The patient remained unwilling to disclose her thought or to try graduated response prevention of rituals. She refused to engage in behavioral experiments to target thought-action fusion for minor negative events unrelated to her OCD or even for positive events (e.g., imagine winning at bingo and see if it happens). Sara stated, "I knew this is what you would say. My family has been telling me for years that my rituals do not have any effect. I can see what you mean that just saying something can't make it happen. But when I get this thought about it in my head, it feels so real, I just can't take the risk." Sara estimated the risk of telling her thought as follows: "I think telling could make it happen 50%, I *feel* telling could make it happen 95%." At the end of the second session the patient said she

might as well give up therapy, because "I absolutely cannot tell anyone my thought or stop my rituals." She reluctantly agreed to return for the third session (prolonged cognitive therapy for 2 hours). The following is an illustration of the use of schema-based conceptualization and intervention to address the Sara's difficulties, starting with her case history.

Sara reported that she was born in Montreal, the oldest of four children. At age 5, her mother contracted a respiratory illness that required long-term hospital care. The patient was placed in an orphanage for a year, separated from her siblings. Her father worked long hours to pay for the mother's care and told Sara he therefore could not care for the children. Her mother visited unpredictably, and Sara recalls feeling "lonely and scared." When she was 6 the family reunited. A few years later, her mother was diagnosed with schizophrenia for which she was hospitalized several times. Sara often took care of her younger siblings. She said she had wanted to do it and did not feel resentful. The therapist asked: "You mentioned you feel that if 'it's hard for you, it's easier on others.' Is there anything you did when growing up to make it easier on others?" The patient replied: "I often stayed home with my mother instead of going out with friends. This made it easier on her; she got sick less often."

When Sara was 10 her father "went off to war." He returned approximately a year later "a changed man." Sara said that he recounted stories to the children of having been tortured; he was withdrawn and unable to work; and the parents separated. At age 16 Sara went to work to help support the family, though she would have preferred to continue school. She recalls the exact onset of an OCD symptom. She was out with friends, who began to talk about the feared event. The thought went through Sara's mind, "How awful that would be." She felt intensely anxious and began to ritualize to relieve anxiety each time this thought came to mind. Her symptoms quickly worsened, and the course of her illness had been constant and severe since then.

The patient married in her 20s and had three sons. After approximately 20 years of marriage, her husband suffered a serious disability following an accident and the patient cared for him. Sara said her rituals did not interfere with her physical care of her children while they

were young ("When it came to my sons, I could stop them"). Her sons expressed shame when Sara did her repeating behaviors in public: "I've had my symptoms for many years, and have never told a soul why. My greatest wish my whole life has been to be able to tell my sons why I did those behaviors all those years that upset them so much. At least they would understand. But that would take a miracle."

With developmental, attachment, and schema theory in mind, the therapist tried to further assess Sara's current belief that "If I tell, it will happen" in the following snippet from the third session.

T. "When you were growing up, did you talk about your feelings?"
P. "I don't know what you mean. Like what feelings?"
T. "Well, if you felt sad, or scared, or annoyed, did you tell anyone?"
P. "Oh no. No, almost never."
T. "Why is that?"
P. "I didn't want to upset anyone. In our family, we kept our feelings to ourselves."
T. "What could happen if you talked about your feelings?"
P. "My mother was sick. I didn't want to upset her."
T. "What's the worst that could happen if she got upset?"
P. "When she got upset she ended up in hospital."
T. "And then how would you feel?"
P. "Terrible. The worst thing was being alone. I'm afraid if I get too upset, I might become crazy like she was."
T. "Is this what you are afraid could happen if you tell me?"
P. "No. If I did tell and it happens, I'd get so upset I'm afraid I'll go crazy. But that isn't why I don't tell."
T. "Did you ever try expressing your feelings when you were growing up? I wonder if you tried, and what happened."
P. "Well, when I was 13 the man next door, he touched my breasts a few times. This upset me and I told my mother."
T. "What was your mother's reaction?"
P. "My mother told me not to tell my aunt because it would upset her. So I never did. I stayed away from that man, I told him he couldn't do it again, and he stopped."
T. "How did you feel about your mother's reaction?"
P. "I agreed with her my aunt should not be upset. I was sorry I told my mother because I could see how upset it made her." (*This was followed by discussion of the effect this incident and mother's reaction might have had on the patient.*)

The therapist hypothesized that through development a cognitive/emotional/interpersonal schema of "telling thoughts and feelings is dangerous" was transformed into "telling thoughts about something dangerous can actually make these happen." It was hypothesized that the emotional strength of Sara's belief "If I tell, it will happen" was intransigent to cognitive therapy because these interventions did not address the experiences and memories that continued (beyond her awareness) to contribute to her strategic processing of thoughts and feelings, the emotional reality and strength of this belief, and the perceived severity of feared consequences (however low their actual probability). The therapist expressed this conceptualization to Sara in the third session:

> When you were growing up, if you said what you thought or felt, something unpleasant and painful actually did happen—your mother and father became very upset. It's normal that this would feel overwhelming to a child. Children are supposed to be able to express their feelings to their parents, but instead, you felt guilty, like it was your fault. It wasn't anyone's fault. Your mother and father became so upset because they were ill. But telling and something bad happening were connected in your experience. As you grew up, this has somehow changed into 'If I tell a thought about an event, this can cause that event to happen.' You see, this can help us understand why these feel very similar and so real to you, even now. The part we have to start with in therapy is your strong feeling, in the present, that telling me a thought can cause that thought to happen. As we discussed in the last session, there is no danger of this. This is impossible. The first step is to tell me what your thought is. I know part of you wants to because you've come for therapy and you've said you've always wanted to tell your sons. It must have been a hard burden for you to carry alone all these years. Do you feel you can tell me now?

Sara said she had never seen it this way, and she burst into tears. Toward the end of the third session she disclosed her thought to the therapist. Here is what Sara told the therapist: "When my father went away to war, he came back a changed man. It ruined our life. I had to go out to work because he couldn't. He told us stories about how he was tortured. My biggest fear all my life has been that another war would break out and my

boys would have to go to it, and would suffer or die. I felt I had to do everything possible to prevent this. Every time a war broke out anywhere in the world, I'd feel so afraid. I'd never listen to the news, run out of the room if it was on in a friend's house. You are the first person I have ever told."

Sara said her SUDS after this prolonged session was 20%. She requested that her sons come to the fourth session so she could tell them. She did so in a very poignant session, which was videotaped. Following these sessions, Sara reported no further difficulty talking about her fear. She responded well to complete ERP for rituals. Her Y-BOCS score dropped from 28 to 7 after 15 sessions. Cognitive therapy also addressed her belief that things should be hard for her; this included assertiveness training for expression of needs and feelings. Her improvement was maintained at a 5-year follow-up.

Case # 3

This case presented in Chapter 7 is elaborated in this section to illustrate broader conceptualization following initial behavioral treatment, and to illustrate a formal CBT format for case write-up that includes schema conceptualizations. Some of the content about initial therapy is repeated here.

Identifying Information: Mary is a 60-year-old married woman, no children, working as an accountant in the United States.

Chief Complaint: Mary requested treatment for exacerbation of symptoms of OCD shortly after she was diagnosed and successfully treated for uterine cancer. She had been told the medical prognosis is excellent ("They got it all") but said the "stress of what I have been through has caused OCD symptoms to recur and I can't control it." She reported mild feelings of depression, but no suicidal ideation. Self-care such as eating, sleeping, and bathing were reported to be normal. No prescribed medication, no substance use reported. A recent check-up with her surgeon and medical tests indicated no recurrence of cancer.

History of Present Illness: The current exacerbation of symptoms began during radiotherapy for cancer. Mary experienced feelings that an increasing number of situations were "contaminated" (e.g., public washrooms, public transportation). She feared becoming ill as well as

just feeling contaminated. She avoided many feared situations; washing rituals took at least 2 hours daily and were increasingly the focus of her emotional responses and thought content.

Mary was first referred to me from the United States 20 years previously for incapacitating OCD. She had suffered from severe OCD symptoms for 15 years prior to the initial consultation with me. She had presented to the initial session wearing plastic bags on her hands and feet and refused to handle forms or cards she considered to be "contaminated." She had reported that "I avoid almost every situation . . . all my belongings are stored in plastic bags . . . I wash my hands 100 times a day and take 4 hour showers daily . . . I have moved from state to state because they have become contaminated. I know this sounds crazy but I'm not."

There was no evidence of a psychotic disorder or thought process. Secondary depression was severe, no suicidal ideation. Mary stated that she recognized that her fears and behavior were "outrageously excessive" but that she felt unable to tolerate strong feelings of "contamination" and urges to ritualize. Initially, she reported no fear of becoming ill: "I just can't stand the feeling."

Mary had reported the following history: At age 29 she graduated as a civil engineer and accepted a position that involved inspection of cesspool and drain instillations. She reported that within a matter of weeks she felt "contaminated" during and after work and felt compelled to take increasingly long showers. In an effort to cope she quit this job and went on disability. However, this change did not affect the rapid illness exacerbation. She experienced rapid "generalization" of fear and sense of contamination (not associated with fear of illness) described as follows: "I became afraid of anyone who worked at that site, and then of any situations or locations they may have touched (subway, restaurants, post office). It did not matter how far away the location was or how long ago someone may have been there. I became consumed with feeling contaminated and with uncertainty as to what was clean or not. I then could not have anything to do with civil servants in general because they *reminded me* of my colleagues. It got to the point that the associations were all in my head. Finally, I have literally moved across five U.S. states in my car because the entire state felt contaminated, with my clothes and other stuff in plastic bags." Thus, initial contact contamination had evolved

into mental contamination (i.e., Mary suffered from all three contamination types).

At initial assessment, the emotional symptoms Mary had reported were anxiety, disgust, and fear of feeling contaminated; fear of feeling anxious (meta-level); intolerance of distress; and hopelessness that she would be able to recover. She reported feeling "intense anger" at previous clinicians who had attempted prior interventions that "did not help me" and at her family for "forcing" these on her. Her thought content centered on external situations that could result in feelings of contamination and how best to avoid these, and she engaged in extensive mental reviews of her activities in an effort to "reassure myself that I had not been "'exposed.'" Central behavioral symptoms were repeated and prolonged washing, checking, and avoidance of numerous situations, including homes of family members perceived as "contaminated."

Mary reported: "I think I have felt out of touch with some of my feelings most of my life . . . if I feel something I may not express it because I expect not to be understood." Although she had several long-standing relationships prior to illness onset she said that she had never lived with a man or married, because: "If you get too close you can be controlled or hurt." At the same time, she reported that she had felt close emotionally with these men, felt love toward them, and sexual relations were "fun." She reported several close long-standing friendships and a close relationship with her sisters and brother, with whom she initiated and received ongoing intimate exchanges.

Psychiatric History: Mary described the following psychiatric history: She sought treatment within a few months of initial symptom onset, and had seen "10 psychiatrists and psychologists." She had tried several prescribed medications, including Anafranil up to 250 mg for a year, and more recently therapeutic doses of SSRIs that she reported reduced symptoms only minimally. Neuroleptics had also been prescribed that Mary discontinued due to side effects: "They were useless and there were too many side effects." Previous psychotherapeutic interventions had included psychodynamic psychotherapy, supportive psychotherapy, and once-weekly ERP with homework to engage in graduated exposure to feared situations. Mary reported her perception: "These all failed completely. No one understood me; everyone thought I was psychotic."

Prior to the initial consultation with me Mary's father and stepmother had committed her to hospital in the United States. Electroconvulsive therapy (ECT) was recommended with the family's signed consent. Mary reported that she stated to the physician: "If you administer ECT to me I will sue you for everything you have. I don't care what my family signed. I refuse it, and I am capable of making these decisions for myself." She did not receive ECT and she discharged herself against medical advice.

Mary's prior treatment trial with me for contact contamination included cognitive therapy for dysfunctional beliefs related to threat and sense of extreme generalization of contamination; strategies for tolerance of distress and disgust; reeducation about "normal" washing and other self care; and intensive naturalistic therapist-assisted exposure and ERP: 2-hour sessions, four times weekly, for 6 weeks with ERP homework between sessions. Mary stayed in a nearby hotel because she did not wish to be admitted to hospital. Treatment was planned collaboratively with the steps outlined and agreed to prior.

Exposure was graduated and ranged from removing plastic bags and simply going for a walk on the street including passing a garbage can (SUDS of 100 initially) to the highest exposure step at Week Six of visiting (with permission) a garage where empty garbage trucks were parked, touching the door handle of the truck, washing her hands normally, and eating lunch. Each step of exposure was therapist modeled. Initial reported SUDS was 100, which then dramatically decreased with repeated ERP. Response prevention for each step of exposure was complete. For example, after walking on the street what Mary would have done on entering her hotel room: lock "contaminated" clothes in a plastic bag, take a 4-hour shower, and not touch anything in the room until "decontamination" was complete. Instead, as preagreed, Mary entered the room, touched everything (including all her belongings), lay between the bedcovers with her contaminated clothes on, and agreed not to shower until the next day (she could brush her teeth).

Although Mary reported her anxiety was 100/100, this decreased to 70 the next day and 30 for the same exposure at third repetition. The advantage of this approach, as explained to the patient, was that the individual does not have to struggle with ritual prevention because

the RP of ERP was conducted so that "decontamination" was not possible so long as the patient agreed not to change hotel rooms. Therapist assistance was progressively faded and then eliminated.

At the end of 6 weeks Mary reported that she was completely ritual and avoidance free. She used public washrooms, transportation, and restaurants; entered buildings where civil engineers worked; drove her car purposely behind garbage trucks, etc. Treatment then focused on generalization of these gains to her home in the United States and on relapse prevention strategies. Mary reported being able to autonomously generalize her improvements in Montreal as well as at home.

I recommended that Mary seek therapy in her home city for issues hypothesized related to OCD. She refused and requested additional sessions with me to work on related issues. Three months later, having maintained her progress, Mary returned to Montreal for an additional 20 sessions of cognitive and behavioral strategies. These sessions focused on helping Mary to identify, modulate, and respond to varied feelings and interpersonal situations; on fears of being hurt in intimate relationships; and on possibilities for an alternate career.

At 10-year follow-up, Mary reported that she had successfully earned her degree as a chartered accountant, and was working full time in a large firm, that she had married, and that "we have a good, loving marriage." She reported that there had been no recurrence of incapacitating OCD, however, she had experienced very significant symptom exacerbations during identifiable stressors and had "tried to use my cognitive therapy and ERP to reduce symptoms."

Personal and Social History: Mary reported her history as follows: Mary's father was a cardiologist. Mary's mother died of cancer when Mary was 4 years old. The patient has two older sisters and an older brother. Within 6 months Mary's father had married his gym partner, who became the stepmother. Her two children from a previous marriage (all older than Mary) entered the family. Mary reported that she experienced the loss of her mother as "extremely traumatic." She said that she was not told about her illness; her mother appeared unwell but no explanation was given; and Mary experienced her death as sudden and overwhelming: "She is the only person who ever loved me. My father didn't talk about feelings and was always at work." Mary recalled that

pictures of her mother were put away soon after her death and there was no discussion of feelings of loss. Mary said she later learned from her uncle that this uncle (also a physician) had advised Mary's father early on to further investigate her mother's lump, but Mary's father had refused: "It's nothing."

Mary said she disliked and did not get along with her stepmother. She described her as follows: "She was controlling, dismissive, and gave her own children preference. I felt further away from my father than ever. He was not there for me. I wanted to go into medicine but they thought I should do engineering because it's so unique for girls. I always hated it and should have said no. I was afraid of her." Mary reported experiencing OCD symptoms for several years as a child, which then remitted until adulthood. These included checking and rearranging her belongings and hiding her possessions so her stepmother could not find them.

Medical History: At the time of initial assessment Mary did not report any medical problems. At current assessment she had been diagnosed and successfully treated for cancer.

Mental Status Check: Mary was fully oriented with good insight despite incapacitating OCD.

DSM IV-R Diagnosis:

Axis I: OCD with secondary depression

Axis II: None

Axis III: first visit none, current visit diagnosis/treatment of cancer

Axis IV: First visit job stressor

Axis V Initial Visit: GAF Current: 31. Best in Past Year: 31

Axis V Current Visit: Current: 70. Best in Past Year 75

Case Conceptualization

Precipitants: First treatment trial stressors of job choice, second treatment trial life-threatening illness

Cross—Sectional View of Current Cognitions and Behaviors:

Intrusion: "This situation is contaminated."

Appraisal: "I can't stand the feeling of contamination and have to do everything necessary to avoid feeling this way."

Feelings: Anxiety, disgust, urge to ritualize and avoid

Behavior: Avoidance and repeated and prolonged washing

During interview, and when she was able to complete dependent measures of symptom-related cognitions, Mary endorsed beliefs such as: "The world is a dangerous place. I am more susceptible to danger than others. Strong feelings are dangerous. I have difficulty with unpredictability, newness, and change; and I need to be in control of everything around me." On the appraisal level following life-threatening illness that was successfully treated, there was an exacerbation of feelings that she is susceptible/vulnerable and the world dangerous.

Longitudinal View of Cognitions and Behavior (please see summary of conceptualization on page 118).

Strengths and Assets: Mary is a bright, insightful, and courageous individual who is able to form good relationships with select friends and family.

Working Hypothesis (summary of conceptualization):

Mary's early attachment and developmental experiences involved traumatic loss and strong feelings that she experienced as insufficiently recognized or soothed. She feared early on—and throughout her life—unpredictable threat, her own strong feelings, and loss of control on a basic "schema" level. She lost her mother (perceived as safe) as a young child and she felt abandoned and unprotected. She experienced interactions with her stepmother as noxious and intrusive. Her specific OCD symptoms were conceptualized as expressions of these strong feelings transformed during development, under stress in adulthood, to a strong feeling of contamination and disgust (including mental contamination), with desperate efforts to avoid these feelings experienced then and now as intolerable and overwhelming. Mary had been able to form trusting and intimate relationships with some family members and with boyfriends, but she experienced some others as noxious or harmful and to be avoided. In fact, she stated that people she did not like (including colleagues) were sometimes experienced as "contaminated."

Current Treatment Plan

Problem List

- Recurrence of intrusive thoughts, appraisals, and urges about contamination Mary felt unable to cope with
- Cognitive and behavioral rituals and avoidance

- Heightened feelings of susceptibility and vulnerability
- Conflictual relationships at work and related feelings of mental contamination

Treatment Goals and Plan

1. Review, practice, and strengthen in session and homework cognitive and behavioral strategies to reduce OCD symptoms (e.g., cognitive therapy, ERP, behavioral experiments).
2. Normalize and decrease feelings of heightened susceptibility and vulnerability that are not uncommon after life-threatening illness, but that are understandably more difficult for Mary to adaptively negotiate.
3. Differentiate between real and exaggerated threat and strengthen coping strategies.

Collaboratively assess and develop strategies for interpersonal issues at work including cognitive strategies such as re-appraisal of disagreement among colleagues, tolerance of feelings such as distress and anger; and social skills and assertiveness strategies with modeling and role-playing. Develop alternate appraisals of, and coping with, feelings of mental contamination (e.g., coping strategies for varied feelings about self and others) combined with/followed by behavioral experiments.

Course of Treatment

Therapeutic Relationship

At the beginning of the first treatment trial, for approximately the first week of intensive sessions, Mary expressed hopelessness that anyone could help her and "fear of being harmed rather than helped by yet another therapist." She asked me to "promise" prior to engaging in ERP that I would be "different" and "could help her."

This was my reply: I said that I thought I understood her feelings, which I take very seriously, the painful suffering from incapacitating OCD, as well as the early childhood and other life experiences she had shared with me. I said I thought our relationship and trust in the

therapeutic process would be likely to develop if/when she experienced therapeutic efficacy. I said that I could not promise or guarantee I could help her but that I would try my best. I presented the collaborative model: we would assess together on an ongoing basis what helped or did not and refine the approach for her treatment collaboratively. I added that I would not have accepted Mary for treatment if I did not think this was worth a try with me as her therapist; that ERP for OCD is a central empirically based intervention; and that based on my clinical experience in general and individualized conceptualization with Mary in particular, in my opinion the specific procedure I recommended was indicated.

As described earlier, the initial trial of intensive cognitive therapy and ERP for OCD was effective. As Mary experienced her anxiety and rituals, etc., decreasing, and her capacity to adaptively cope with feelings and situations improving, her trust in the therapist and sense of self-efficacy grew (trust scale was "0.5/10" at treatment onset and "expanded 10" at end of 6 weeks). At the end of the 6 weeks Mary stated: "I trust you with my life. This was a miracle for me. I still can't believe what I was able to do. I feel I can trust you with my feelings . . . you get me . . . It really helped that we did complete RP, that you modeled every step of ERP along the way in the scary situations. I wasn't left alone to just leave your office and then go home and face fears . . . I was not capable of this and you knew it . . . I know I'll never get back what I lost when my mother died . . . but you helped me face what I was most afraid of . . . I feel safe with you as I imagine I would have felt with my mother had she lived. I didn't believe this would ever be possible for me." (Mary was crying as she spoke.)

Obstacles: Mary lived in a large U.S. city where there are several therapists whose excellent work I was aware of. The central serious obstacle was that Mary refused my recommendation to seek follow-up therapy in her home city. This was despite my offer to help with the transition; to recommend specific therapists whose work I am familiar with; and (with Mary's permission) to write a thorough report and to speak with a new therapist of her choice. I told Mary that, in my opinion, successful intensive ERP should be followed by additional regular sessions to maintain progress as well as, importantly, to further address difficulties that might render Mary susceptible to exacerbation of symptoms under stress. These included difficulty adaptively coping with feelings (anxiety,

uncertainty, and anger) and fear of interpersonal situations. The interventions I recommended included cognitive therapy for thoughts and feelings on the appraisal level and schema-based cognitive therapy to address relevant attachment and developmental experiences and their effect on current cross-situational functioning, combined with behavioral experiments and skills interventions.

Mary said that she agreed she was experiencing these difficulties. She viewed these as linked to OCD, and she very much wished to work on these, "but only with you." She said: "I recognize there are probably other skilled therapists but I am not willing to see anyone else." I said I understood that changing therapists is understandably very difficult, but Mary had experienced the capacity to trust me as well as other significant others in her life, therefore, in my view, she could likely learn to trust another therapist.

My efforts to work on the reasons/feelings for Mary's refusal to see another therapist largely failed. She reported that she had tried to see someone briefly but had discontinued. Our conceptualization of this refusal was that Mary had lost her mother, she perceived me as a safe and caring "mother figure" (with insight intact and without other evidence of excessive dependence on me), and she was not willing to go elsewhere. Mary requested to attend follow-up sessions with me, as needed, which she did some years twice yearly for a week at a time and then not at all for several years.

Outcome: Mary reported that she had benefitted from the most recent treatment trial. She was able to generalize the ERP to home with significant reduction in rituals and avoidance. She stated that her interpersonal functioning with her colleagues and boss had improved to the point she was recently offered additional responsibilities. She said she still felt vulnerable to future illness, but thought "much less about this."

Following the initial successful treatment trial, Mary had never again experienced incapacitating OCD. She worked full time, had a supportive and loving relationship with her husband (I have met with her husband, who agrees), and reported improved capacity to identify and to adaptively cope with feelings and interpersonal situations. For most of the process, she negotiated diagnosis and treatment of recent life-threatening illness

relatively well. However, she remained quite susceptible to exacerbation of OCD symptoms under significant life stress. Her greatest source of current ongoing sense of contamination emanated from conflictual relationships at work. When Mary did not like someone, or felt put down by them, she felt "contamination and disgust" and took lengthy showers prior to touching objects in her home (i.e., mental contamination). The frequency of sessions with me were deemed to be inadequate to sufficiently ameliorate these symptoms.

Among the most emotionally significant experiences with a patient during my career occurred with Mary. During one of the follow-up visits, while Mary was sitting in my office, I learned that my mother had died suddenly of a massive heart attack. I told Mary that I would have to stop the ongoing session, that with regret I would have to cancel the scheduled sessions for that visit, and I told her the reason. Mary later let me know that she had experienced the verbal and nonverbal communication between us during those moments as very meaningful and helpful to her, given her expression of feelings during therapy about her own mother's death and their profound lifelong significance to her.

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Chapter 11

Intervention Criteria for an Optimal Trial of Specialized CBT for OCD, Criteria for Recovery, Criteria for CBT Resistance

The development and refinement of treatment-interventions is ongoing by OCD researchers globally, in order to improve treatment-response and to identify intervention-related and patient-related predictors and mediators of response. Progress in multisite outcome research requires development and consensus on criteria for sustained well-being and recovery, based on multidimensional indices of change (Pallanti et al., 2002; Simpson, Huppert, & Petkova, 2005; Sookman and Steketee, 2007, 2010; Farris, McLean, Van Meter, Simpson, & Foa, 2013). Theoretically, individuals are susceptible to relapse if rituals, avoidance, or maladaptive safety behaviors persist in response to feared events. Sookman and Steketee (2007, p. 6, adapted slightly here) outlined the following general criteria as reflective of in-process treatment resistance, based on the assumption of application of evidence-based treatment protocols: (a) the patient does not participate fully in exposure (ERP or behavioral experiments) so that some avoidance remains; (b) the patient does not engage in and/or sustain complete response prevention during and/or between sessions; (c) residual behavioral or cognitive rituals persist; and (d) symptom-related pathology such as beliefs or other experience (e.g., incompleteness) are not resolved to within normal limits. The latter criterion requires empirical

investigation. Susceptibility to maladaptive reactions to intrusions (and indeed obsessions) may persist or reoccur under stress without relapse if the patient's *strategic processing is corrective* (Sookman & Pinard, 2007, please see case illustrations in Chapter 7). The following adaptive reappraisals are a further illustration of corrective strategic processing: "I had an image of stabbing my child [*intrusion*]. This means I could become a murderer, what if that means I'll actually do it? [*appraisal*]. No, as I learned in therapy, that appraisal is inaccurate. It's just a harmless thought. I feel scared, and I have the urge to check that my daughter is OK. But, as I learned in therapy, this feeling is not a reliable index of actual danger. I will not let it affect my behavior." With practice the aim is development of a more adaptive strategic processing "attitude" and emotional response to inner experience that do not necessarily require reappraisal "self-talk."

Criteria for an Optimal Trial of Specialty CBT for OCD

The intervention criteria proposed for an optimal trial of specialized CBT for OCD are based on current research and the author's own clinical experience, adapted here from Sookman & Steketee, 2010, pp. 62–63.

1. Specialized evidence-based CBT is administered by a therapist, or under the supervision of a therapist, experienced in treating OCD. As a general guideline, the therapist should have engaged in supervised CBT with at least 10 and preferably 20 OCD patients of varying subtypes. Considerably more supervised experience with additional competencies is required to administer the additional schema-based interventions described in Chapter 10, as well as for patients who have not responded well to an initial trial of CBT.
2. Multidimensional assessment of symptoms, comorbid conditions, medical status, skills repertoire, resources, and psychosocial and intra-familial functioning has been adequate to formulate an evidence-based individualized CBT case conceptualization and treatment plan, which evolves with the patient's active collaboration during treatment.
3. Assessment strategies include standardized scales to assess subtype and severity of OCD symptoms, comorbid conditions, beliefs, emotional distress, quality of life, and other relevant variables such

as degree of insight, with direct behavioral observation and interviews with significant others when possible (with patient consent). Idiographic record keeping (RK) during treatment may be helpful for select cases. There are frequently occurring contra-indications to assignment of RK homework for OCD. For example, patients already "flooded" and hyperattentive to their intrusive thoughts should not be asked to keep records of these; similarly, it is not helpful to request RK at onset of treatment from patients with difficulty writing.

4. Treatment has included delivery of subtype specific evidence-based CBT that includes subtype specific cognitive therapy with ERP and/or behavioral experiments. Cognitive therapy addresses appraisals of intrusions, beliefs, feelings and other experience (e.g., incompleteness), and metacognitive dysfunction characteristic of OCD. Behavioral experiments with response prevention are planned and assessed with specific predictions and disconfirmations specified. ERP includes planned prolonged exposures and prevention of rituals and avoidance behaviors triggered by the exposures, with the aim of achieving complete ERP. These treatments are directed at all subtypes of OCD symptoms present and are constructed in collaboration with the patient.
5. At least 40 hours of therapy are delivered in intensive or spaced formats with therapist assistance unless the patient recovers sooner. If clear progress is evident but the patient is not scoring in the subclinical range on OCD symptoms, additional treatment should be provided. If spaced in-office sessions (e.g., once weekly) do not produce clear evidence of improvement after 10 hours, treatment should be intensified (two or three times weekly or even daily), session duration should be lengthened (90 minutes or more), and cognitive therapy and behavioral methods should be practiced with therapist assistance in relevant naturalistic environments.
6. Relevant daily cognitive therapy and ERP and/or behavioral experiments homework is assigned, monitored, and adjusted regularly during sessions and adherence is regularly assessed.
7. Skills limitations have been identified and addressed with skills acquisition interventions (e.g., emotion tolerance and modulation, interpersonal skills, decision making).

8. Family/significant other difficulties that may impede improvement are addressed in meetings with significant others. Unless this is deemed inappropriate, significant others receive education about OCD, recommendations for adaptive responses to the patient's symptoms, and strategies to reduce accommodation to symptoms and to foster healthy functioning. Recommendations are provided with the patient's knowledge and prior consent (except in emergencies) and are congruent with the patient's progress in treatment (e.g., degree/level of ritual prevention).
9. Referral for prior or concurrent pharmacological treatment is evidence-based (i.e., comorbid disorders or symptoms that require medication). When optimally delivered CBT produces limited response by mid-treatment, medications should be added when hypothesized reasons for poor outcome suggest a need for medication rather than change in psychological strategy. Pharmacotherapy dosages are developmentally adapted and evidence based, and adherence is monitored.
10. Therapy/therapist fading, generalization, and relapse prevention strategies are provided. Fading requires that the therapist and family members/significant others assisting in office or home-based sessions reduce the frequency and intensity of their involvement over time. Hospitalized patients should receive regular outpatient sessions following discharge for at least 6 months, with a graduated reduction schedule thereafter. Generalization requires application of cognitive therapy and behavioral methods across a broad range of situations in which symptoms occur to optimize learning across relevant contexts. Methods to sustain gains require continued application of strategies learned in therapy such as reappraisals and ERP. Termination sessions include planning and practice of specific adaptive coping with potential future triggers.
11. Treatment-interfering behaviors have been identified and addressed.
12. Booster sessions are provided as needed.
13. Every effort is made to achieve symptom recovery using evidence-based interventions and to insure that "treatment resistance" does not constitute a technical treatment failure (i.e., due to intervention inadequacies). Consultation or ongoing supervision with an OCD expert is

undertaken or the patient is referred for treatment to an OCD expert in order to optimize symptom recovery.

Response Criteria for Recovery Following CBT for OCD

Sookman and Steketee, 2010 (p. 64) proposed the following criteria for recovery following specialized CBT for OCD (Criterion 9 is updated here):

1. The patient no longer meets diagnostic criteria for OCD.
2. Y-BOCS total score is 7 or lower.[1]
3. No subjective distress due to OCD symptoms.
4. No rituals are performed (minimal obsessions and urges to ritualize may occur).
5. No avoidance of previously feared situations and OCD triggers.
6. Dysfunctional appraisals and beliefs, and other OCD-related symptoms such as secondary depression, "not just right," sense of incompleteness, etc. are resolved to within normal limits (see scores for normal controls on cognitive measures; OCCWG, 2003).
7. Absence of functional impairment, or return to premorbid level of function if high, in multiple life spheres including work, activity level, and interpersonal relationships.
8. The patient cooperated fully in cognitive therapy and ERP and/or behavioral experiments.
9. Improvement is maintained for at least one year.[2]

Thus, optimal treatment response refers to recovery rather than only clinically significant improvement. Patients with a Y-BOCS score below l6 at posttreatment would not meet the criteria for a clinical trial; however, they continue to suffer noticeable symptoms that adversely impact quality of life. Further, persistent symptom-related distress, dysfunctional beliefs, rituals, and avoidance maintain psychosocial dysfunction and can contribute to relapse.

Following from the listed criteria for optimal treatment and for recovery, Sookman and Steketee (2010, pp. 64–65) proposed that a patient be considered resistant to CBT if the following response criteria are met after an optimal trial of CBT has been delivered or attempted.

Criteria for CBT Resistance in OCD

1. The patient continues to meet diagnostic criteria for OCD.
2. Y-BOCS total score of 14 or higher and/or less than 50% improvement in OCD symptoms from pretreatment.[3]
3. Mild or greater subjective distress due to OCD symptoms.
4. Continued rituals are performed in response to obsessions and urges to ritualize.
5. Continued avoidance of feared situations and OCD triggers.
6. Dysfunctional beliefs and other OCD-related symptoms, such as secondary depression, remain within dysfunctional limits (see scores for OCD clinical samples on cognitive measures; OCCWG, 2003).
7. Mild or greater functional impairment due to OCD symptoms in one or more quality of life spheres including work, activity level, and interpersonal relationships.
8. Refusal to cooperate fully in cognitive therapy and ERP and/or behavioral experiments. Reasons for refusal have been directly addressed without success and consultation and/or supervision with an OCD expert has been undertaken.
9. Improvement is not maintained at a short-term follow-up of 6 months, with a sustained worsening of OCD symptoms by 25% or more since end of treatment.

Indications for Future Research

Further controlled research on treatment developments described throughout this volume for OCD subtypes is required. Among the important questions are what are the optimal processes of treatment administration, specific therapeutic ingredients, and mediators of sustained change. The degree of improvement in cognitive, emotional, and behavioral responses to inner and external events, with sustained practice of adaptive skills taught in therapy, may be among the best predictors of long-term outcome. Further research is required to examine factors that optimize adherence during as well as following treatment. Sookman and Steketee (2010) and other authors have advocated that, as is the goal for

other disorders, *recovery* and not merely symptom reduction is the goal of treatment of OCD. Statistical significance of mean change scores and pre-post effect sizes, although important, are of limited value. In order to increase generalization of findings exclusion criteria should be minimized (e.g., Moher, Schulz, & Altman, 2001). Examination of recovered patients and their characteristics compared with others on the continuum of recovery is required for further development and refinement of interventions.

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Chapter 12

Summary

Treatment for OCD and related disorders is a highly specialized field. In this volume I have summarized the knowledge and clinical competencies required by clinicians treating OCD, with description and illustration of specialized CBT approaches developed for specific subtype characteristics and for complex presentations. Further research is required to examine and refine these interventions, and to develop new approaches using multidimensional and stringent outcome criteria, with examination of mediators of sustained change. The goal of specialized treatment for OCD, as for other disorders, is recovery. Available research indicates that recovery is possible for at least some cases of OCD. Recommended criteria for an optimal trial of specialized CBT as well as criteria for recovery and for treatment resistance are outlined in Chapter 11. The current literature underlines the importance of direct access to specialized tertiary care for OCD patients as soon as possible following emergence of symptoms in order to optimize recovery. To further examine response rates and mediators of long-term improvement randomized controlled outcome trials should optimize treatment characteristics (e.g., sufficient frequency, intensity, location of sessions, and treatment duration), and should report and characterize those patients who recover, those who achieve clinically meaningful improvement (i.e., into mild range), and those who do not achieve such benefits. Translational research may help to identify mechanisms underlying treatment and differences in response on the continuum from CBT resistant

to recovered. Outcomes should be examined at posttreatment and long-term follow-up, whenever possible. It is important to define treatment resistance to specialized CBT as an interaction of intervention factors and patient characteristics *in the context of evidence-based optimally delivered interventions*, and to differentiate between frequently occurring "technical treatment failures" (due to intervention inadequacies) and serious treatment failures. Multisite collaboration is needed to improve integration of evidence-based findings from controlled research into clinical practice. There is a well-documented and dire insufficiency of clinicians qualified to deliver specialized CBT for OCD and related disorders. Therefore, the need to disseminate expertise in this field is urgent. *A central issue to be addressed by OCD experts is how to best disseminate expertise available at specialized OCD clinics* (please see the Canadian Institute for Obsessive Compulsive Disorders, http:/www.ciocd.ca).

Notes

4 "Resistance" to Specialized Cognitive Behavior Therapy for OCD

1 Adapted from Sookman & Steketee, 2010, pp. 38–40.

5 The Scientist–Practitioner Model

1 Please note that I recommend the OBQ-87 compared with the OBQ-44 because the former has separate subscales for threat estimation and responsibility, reflecting the clinical picture for many patients.

7 Treatment of Contamination

1 Adapted from Sookman & Steketee, 2010, pp. 49–56.

2 In developing this clinical strategy specifically for OCD, we built upon the conceptual and treatment model of OCD proposed by Sookman, Pinard, and Beauchemin (1994); the general information processing model of anxiety proposed by Beck and Clark (1997); and the model of vulnerability schemas in OCD proposed by Sookman, Pinard, and Beck (2001).

3 Adapted from Sookman & Steketee, 2007, pp. 8–9.

10 A Schema-based Model

1 Adapted from Sookman & Steketee, 2007, pp. 11–13, with permission.

11 Intervention Criteria for an Optimal Trial of CBT, Criteria for Recovery, Criteria for CBT Resistance in OCD

1 Within normal range, ≤ 1 standard deviation above the mean for normal controls reported by the OCCWG (2003); 2.5 (mean) + 4.3 (standard deviation) = 6.8; *n* = 87.

2 In response to current research the duration of sustained improvement is recommended to be a minimum of one year.

3 Within mild range of OCD symptom severity, ≥ 1 standard deviation below the mean for clinical OCD samples reported by the OCCWG (2003); 20.5 (mean) − 6.9 (standard deviation) = 13.6; *n* = 248.

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