CHAPTER 7

Obsessive–Compulsive Disorder in Adults

The hallmark feature of obsessive–compulsive disorder (OCD) is the presence of obsessions, compulsions, or both. Diagnosing OCD can often be challenging due to the overlap in features with other conditions, including tic disorders, impulse control disorders, obsessive–compulsive personality disorder, somatoform disorders, GAD, phobias, eating disorders, psychotic disorders, and depression. Given the overlap with other disorders, we recommend readers review recommendations for diagnosis and classification of OCD elsewhere before they select and treat patients in a CBT group (Abramowitz & Jacoby, 2015; Van Ameringen, Patterson, & Simpson, 2014). DSM-5-TR provides official symptom criteria that qualify an individual to receive a diagnosis of OCD, the core features of which include obsessions and compulsions.

Obsessions may be described as cognitions, urges, or mental images that occur over and over that are unwanted, upsetting, or intrusive, and that individuals try to avoid (see American Psychiatric Association, 2013, for a definition of obsessions). Common obsessions include concerns about contamination (e.g., fear of germs, diseases, detergents, chemicals, toxins, and various other perceived contaminants); doubts about actions (e.g., whether doors are locked, appliances have been left on, there are errors in one's written work, one has hit a pedestrian while driving); religious beliefs (e.g., thoughts of a religious nature that are distressing, such as blasphemous images or thoughts about being possessed by the devil); sexual thoughts and images (e.g., irrational doubts about one's sexual orientation, irrational thoughts about sex with a child or some other inappropriate

partner); aggressive thoughts (e.g., intrusive thoughts of hurting a loved one); thoughts of accidentally harming oneself or others; and impulses to have things exact, in a particular order, symmetrical, or just right (Antony, Downie, & Swinson, 1998).

Individuals with OCD may also experience compulsions, which are repeated behaviors that are done to reduce discomfort caused by obsessions or according to rigid rules (see American Psychiatric Association, 2022, for a definition of compulsions). Typical compulsions include excessive washing, cleaning, checking, reassurance seeking, repeating actions, counting, praying, hoarding, and restating things (Antony, Downie, et al., 1998).

OCD is a heterogeneous condition. Although symptom overlap is common, symptoms sometimes shift from one cluster to another over time, and most individuals with OCD do not experience all of the symptoms described in this section. For example, some individuals have symptoms focused exclusively on concerns related to contamination and washing, whereas others may have symptoms that cut across several content areas.

Cognitive and Behavioral Features of OCD

Cognitive Features

Cognitive-behavioral models of OCD emphasize the importance of beliefs, appraisals, and other cognitive features in the cause and maintenance of OCD. The Obsessive Compulsive Cognitions Working Group (2001, 2003) identified six belief domains that are relevant to OCD: (1) inflated responsibility, (2) overimportance of thoughts, (3) excessive concern about the importance of controlling one's thoughts, (4) overestimation of threat, (5) intolerance of uncertainty (IU), and (6) perfectionism. In this section, we consider a number of these domains, as well as several related cognitive features (e.g., attention and memory biases, magical thinking, thought–action fusion [TAF]) that are relevant to the understanding and treatment of OCD. A comprehensive review of the role of cognition in OCD is available elsewhere (e.g., Radomsky & Alcolado, 2012; Taylor, Abramowitz, McKay, & Cutler, 2012).

Metacognition

The term "metacognition" refers to a belief that an individual has about their beliefs (e.g., the belief that one must control or prevent intrusive thoughts, the belief that one's thoughts are dangerous or very important in some way). Most cognitive models of OCD emphasize the role of metacognitions, arguing that it is clients' beliefs about their obsessions that maintain the disorder. Researchers have begun to generate data confirming the importance of metacognitive factors for understanding OCD (e.g., Wells, Myers, Simons, & Fisher, 2017).

Attention and Vigilance

Although the literature is somewhat inconsistent, overall there is little evidence that individuals with OCD are biased to attend to *general* threat cues more closely than individuals without OCD (e.g., Moritz, Wendt, & Kluwe, 2004). However, there is evidence that individuals with OCD (particularly those with contamination concerns) may be vigilant for information related to their specific obsessions (Armstrong, Sarawgi, & Olatunji, 2012; Sizino da Victoria, Nascimento, & Fontenelle, 2012).

Memory Biases

Research results on memory and OCD have also been mixed. Although some studies have failed to find general memory deficits in OCD, meta-analytic reviews have concluded that individuals with OCD are impaired on tasks requiring working memory (Snyder, Kaiser, Warren, & Heller, 2015) and episodic memory (Shin, Lee, Kim, & Kwon, 2014). There is also evidence that people with contamination obsessions tend to have better memory for contaminated objects than for clean ones (Radomsky & Rachman, 1999), and that individuals with OCD have difficulty forgetting threat-related information when instructed to do so (Wilhelm, McNally, Baer, & Florin, 1996) compared to people without OCD. Regardless of whether people with OCD actually have memory deficits, it is fairly clear that individuals with OCD have a lack of cognitive confidence (i.e., distrust of attention, perception, and memory; Ouellet-Courtois, Wilson, & O'Connor, 2018). Furthermore, repeated checking seems to reduce confidence in one's memory even further (Radomsky & Alcolado, 2010).

Magical Thinking

Magical thinking involves assuming that there are associations between events that in reality are not related. Though not everyone with OCD engages in magical thinking, OCD symptoms do tend to be correlated with measures of magical thinking (Einstein & Menzies, 2004). Examples of magical thinking include beliefs such as "If I do everything seven times, I can prevent bad things from happening" and "If I step on a sidewalk crack, I'll break my mother's back."

Thought–Action Fusion

TAF refers to the tendency to view thoughts and actions as equivalent. Examples of TAF include the belief that thinking about harming a loved one is the moral equivalent of actually doing it, or the belief that thinking about doing something horrible increases the likelihood of acting on the belief. TAF is a common feature of OCD (Bailey, Wu, Valentiner, & McGrath,

2013; Rachman & Shafran, 1999) and, in our clinical experience, is particularly relevant in people with religious, aggressive, and sexual obsessions. Conceptually, TAF may be best thought of as a subtype of magical thinking (Einstein & Menzies, 2004). Recent research suggests that TAF can be corrected through standard CBT techniques, such as psychoeducation or behavioral experiments (Zucker, Craske, Barrios, & Holguin, 2002).

Perfectionistic Thinking

"Perfectionism" may be defined as a tendency to set standards that are both rigid and unattainably high, and is a feature of several disorders. Individuals with OCD tend to show higher levels of perfectionism compared to people without anxiety disorders. In particular, they are overly concerned about making mistakes, and they also report excessive doubts about whether they have done things correctly (Hood & Antony, 2016; Pinto et al., 2017). Clinically, some clients also present with excessive attention to detail and a need to have things "just right."

Inflated Responsibility

A growing literature suggests that individuals with OCD often have an inflated sense of responsibility (see Neal, Alcolado, & Radomsky, 2017, for a review), meaning that they tend to be overly concerned that their actions and thoughts will lead to negative consequences, or that failing to act will lead to negative consequences. The construct of inflated responsibility is closely related to some of the other cognitive features of OCD discussed earlier, including perfectionism, TAF, and magical thinking. Examples of OCD presentations that may reflect a sense of inflated responsibility include the following:

- A person who repeatedly asks for reassurance that others are not offended by something they said.
- A lawyer who spends hours reviewing reports and letters to ensure that everything is accurate, so harm will not come to their clients.
- A new mother who avoids spending time with her baby for fear of acting on intrusive sexual obsessions.

Overestimation of Threat

As with all anxiety-related disorders, people with OCD often judge situations to be much more dangerous than they really are. For example, perfectly safe objects may be viewed as contaminated, or the perceived consequences of making mistakes may be exaggerated. The tendency to overestimate threat has been found to be correlated with the severity of symptoms, such as washing, checking, doubting, obsessing, mental neutralizing, and

hoarding (Tolin, Woods, & Abramowitz, 2003). In addition, compared to people without OCD, people with OCD tend to request more information and tend to spend more time deliberating before making decisions about low-risk situations and about situations relevant to their OCD (Foa et al., 2003).

Intolerance of Uncertainty

The inability to tolerate ambiguity and uncertainty is pervasive across anxiety and related disorders, such as GAD, SAD, and OCD. Research has shown that IU is an important feature of OCD (Sarawgi, Oglesby, & Cougle, 2013; Tolin, Abramowitz, Brigidi, & Foa, 2003). The heightened desire for certainty is especially problematic given the tendency for OCD clients to be uncertain about things. As reviewed earlier, doubts about actions and a lack of confidence in memories are common features of OCD.

Behavioral Features

The most common behavioral features of OCD may be conceptualized either as avoidance behaviors or as compulsions, both of which are used to prevent harm or to reduce discomfort. The distinction between avoidance behaviors and compulsions is often blurred. For example, suppression of intrusive thoughts (an example of an avoidance behavior is listed below) can just as easily be conceptualized as a cognitive compulsion.

Avoidance Behaviors

People with OCD often avoid situations that trigger their obsessions and fear. For example, people who fear contamination avoid objects that are perceived as contaminated, and individuals who fear hitting pedestrians while driving may avoid driving, particularly in areas with pedestrian traffic. Avoidance may also be more subtle. For example, people with OCD engage in various forms of cognitive avoidance, including distraction, suppression of intrusive thoughts, and replacing intrusive thoughts with neutral ones (e.g., Purdon, Rowa, & Antony, 2007; Starcevic et al., 2011). Like other forms of avoidance, cognitive avoidance is thought to be counterproductive, serving to maintain anxiety and distress over the long term (Purdon, 1999).

Compulsions and Other Protective Strategies

One of the hallmark symptoms of OCD is compulsive rituals, the most common of which include checking, washing and cleaning, counting, repeating actions, and repeating phrases. Frequent reassurance seeking is another common compulsion used to reduce anxiety triggered by doubts

about one's actions, intrusive thoughts, or memories. Reassurance is often sought from family members, therapists, books, and other sources.

People with OCD often engage in other protective behaviors as well. For example, people with contamination fears may wear gloves to prevent contaminants from getting on their skin. People who fear leaving their small appliances on may unplug them and bring them to work each day, just to be sure. Reliance on safety cues (objects or people whose presence engenders a sense of safety) is also common in OCD and other anxiety disorders. Finally, some clients with OCD tend to overrely on substances as a way of managing their discomfort (Blom et al., 2011; Mancebo, Grant, Pinto, Eisen, & Rasmussen, 2009), though alcohol and drug use may be less of a problem in OCD than in certain other anxiety disorders.

Cognitive-Behavioral Approaches to Understanding OCD

Early behavioral models of OCD (e.g., Meyer, 1966) were based on traditional learning theories, such as Mowrer's (1960) two-factor model for the development of fear. According to Mowrer, fear is initially triggered through classical conditioning, in which a previously neutral stimulus (e.g., a dog) is associated with some negative event or experience (being bitten), and subsequently becomes an object of fear. Fear is thought to be maintained through operant conditioning processes (specifically, negative reinforcement), in which the avoidance of the feared object or situation maintains the problem over time by reducing the uncomfortable feelings of fear and anxiety, and providing a sense of relief. In the case of OCD, learning models assume that obsessive–compulsive symptoms begin after some sort of classically conditioned negative event. For example, developing food poisoning might lead to a fear of contamination, or losing something important might lead to excessive checking. By engaging in various avoidance behaviors and compulsive rituals, the individual with OCD increases the likelihood that their symptoms will continue over time.

Despite their intuitive appeal, learning models of OCD have not been well supported by research (e.g., see Jones & Menzies, 1998). Therefore, theorists have turned their attention to cognitive and cognitive-behavioral approaches to better understand OCD (e.g., Rachman, 1997, 1998, 2002; Rachman & deSilva, 1978; Salkovskis, 1985, 1998). Two core features of current cognitive-behavioral models of OCD are the notions (1) that individuals with OCD have an exaggerated sense of responsibility for causing or preventing harm, and (2) that metacognitions (i.e., beliefs about intrusive thoughts) are key to understanding this condition.

For example, Salkovskis (1998) reviewed research showing that almost 90% of individuals in the general population experience intrusive thoughts that are similar in content to clinical obsessions, and argued that what distinguishes normal intrusive thoughts from clinical obsessions is not the

nature of the thoughts but rather the way in which the individual interprets the thoughts. According to Salkovskis, intrusive thoughts become a problem when they are interpreted as an indication that an individual may be responsible for either causing or preventing harm to oneself or others. For example, if a person believes that the thought "I will stab my child" increases the chances of doing so, they might be inclined to make efforts to suppress the thought and to avoid sharp objects, such as knives. Behavioral compulsions, attempts to suppress thoughts, and efforts to neutralize obsessions are thought to reinforce the individual's fear of the intrusive thoughts by preventing them from learning that the thoughts are not dangerous. The model appears to be best suited to explaining OCD profiles that involve an intense fear of one's intrusive thoughts (e.g., sexual, aggressive, and religious obsessions).

As another example of a cognitive theory, Rachman (2002) published a model of compulsive checking. According to this theory, compulsive checking occurs when people believe that they have a heightened responsibility to prevent harm and are unsure whether the perceived threat has been removed. For example, a pharmacist who has obsessions about giving customers the wrong medications, and who doubts his memory about what medications he has dispensed, may check his work repeatedly. According to Rachman, three factors that contribute to the intensity of checking are (1) the level of perceived responsibility, (2) perceived likelihood of harm, and (3) perceived seriousness of harm. The Obsessive Compulsive Cognitions Working Group (2001, 2003) further extended the cognitive model of OCD by identifying six domains of beliefs (discussed previously), although more recent research has called into question whether these beliefs are inherently pathological and whether they are central to OCD pathology (Cougle & Lee, 2014). However, these cognitive features remain central to the conceptualization and treatment of OCD.

Evidence-Based Treatments for OCD

Evidence-based treatments for OCD include pharmacotherapy and psychological treatments, such as behavior therapy and CBT. In addition, several long-term follow-up studies suggest that up to half of clients with treatment-refractory OCD report significant benefit following psychosurgery (e.g., cingulotomy, anterior capsulotomy), with relatively few side effects (e.g., Dougherty, Rauch, & Jenike, 2012). However, because of the intrusive nature of psychosurgery and a lack of controlled studies, these procedures are currently used only in the most severe, refractory cases. Recent research has also shown that deep-brain stimulation (DBS) may show promise for treatment-resistant OCD, as evidenced by a meta-analysis showing clinically significant reductions in OCD symptom scores for individuals treated with DBS (Kisely et al., 2014). This section provides a brief review of the current status of pharmacological and psychological approaches to treating

OCD. More comprehensive reviews may be found in a number of sources (e.g., Abramowitz & Buchholz, 2020; Berman, Schwartz, & Park, 2017; Grancini et al., 2020; Öst, Havnen, Hansen, & Kvale, 2015; Stewart & Loh, 2017; Van Ameringen et al., 2014).

Pharmacotherapy

Numerous studies have shown that the selective serotonin reuptake inhibitors (SSRIs), such as sertraline, fluoxetine, fluvoxamine, paroxetine, and citalopram, as well as the tricyclic antidepressant clomipramine, are effective in reducing OCD symptoms (e.g., Fineberg, Reghunandanan, Brown, & Pampaloni, 2013; Skapinakis et al., 2016). In general, although SSRIs are considered to be the first-line pharmacological treatment for OCD, there is some support for SSRI augmentation with other agents, such as risperidone (see Dougherty et al., 2012, for an extensive review). Further, despite the relative paucity of support for alternative pharmacological monotherapies, there is emerging evidence that suggests that glutamatergic agents and serotonin norepinephrine reuptake inhibitors may be a promising avenue for OCD treatment (Dougherty et al., 2012).

There is no evidence that any single SSRI works better than any other. In addition, although effect sizes have tended to be largest in studies using clomipramine, head-to-head comparisons of SSRIs and clomipramine have found them to be equivalent (see Fineberg et al., 2013, for a review). The decision of which medication to use typically involves considering the evidence regarding efficacy, as well as available information on side effects, interactions with medications that the individual may be taking, possible effects on medical conditions from which the person suffers, previous response to medications taken by the client, and previous response to medications taken by family members of the client. Because SSRIs have a more favorable side effect profile than clomipramine, medication treatment for OCD typically begins with an SSRI. If the chosen medication does not lead to the desired reductions in symptoms after 12 weeks of treatment at an adequate dose, it is reasonable to switch to another SSRI and then to clomipramine (see Grancini et al., 2020, for recommended guidelines).

Psychosocial Treatments

Over the past few decades, exposure and ritual prevention (ERP) has emerged as the psychological treatment of choice for OCD. "Exposure" involves gradually confronting feared situations (e.g., touching contaminated objects; purposely making errors in one's written work; doing things the "wrong" number of times; exposing oneself to anxiety-provoking words, thoughts, or images). "Ritual prevention" (or "response prevention") refers to the process of eliminating compulsions, rituals, and protective behaviors.

Research supporting the use of ERP for OCD goes back more than 40 years, beginning with the work of Victor Meyer (1966). A large number

of controlled outcome studies have demonstrated that ERP is an effective treatment for OCD (see Berman et al., 2017; Blakey, Reuman, Jacoby, & Abramowitz, 2017, for a review). Generally, studies support the use of either intensive treatment (consisting of daily sessions for about 3 weeks, administered in either a day treatment or inpatient format) or a less intensive, outpatient-based treatment (often with two or three sessions per week). More recently, a 4-day concentrated exposure treatment was found to be effective, with a 6-month remission rate of nearly 70% (Hansen, Hagen, Öst, Solem, & Kvale, 2018). In one review of 12 ERP studies including about 330 participants, Foa and Kozak (1996) identified 83% of clients with OCD as responders. Furthermore, gains were generally maintained over time, with 76% of clients (from a group of 376 clients in 16 studies) still being considered responders at a mean of 2.4 years following the end of treatment (Foa & Kozak, 1996).

A meta-analysis by Abramowitz (1996) identified several factors that contribute to improved ERP outcomes. Generally, protocols in which strict ritual prevention instructions are given (as opposed to gradual or partial ritual prevention), protocols that include therapist-assisted exposure (as opposed to only self-exposure), and protocols that include both imaginal and *in vivo* (i.e., situational) exposure (as opposed to only *in vivo* exposure) lead to the best results. However, of note, in a subsequent meta-analysis of 16 controlled studies of ERP, Abramowitz, Franklin, and Foa (2002) found that the average OCD symptom reduction across studies was 48%, suggesting that most people continue to struggle with their OCD to some extent, even after successful treatment.

In light of recent cognitive models of OCD, and because ERP leads only to partial improvement in many clients, investigators have begun to examine the benefits of using cognitive strategies. Cognitive therapy (CT) involves teaching clients to identify and challenge unrealistic anxious beliefs by examining the evidence regarding the beliefs and conducting behavioral experiments to test whether negative beliefs are true. To date, studies have mostly focused on comparisons of CT to traditional behavioral treatments, and in most cases, CT has been found to be an effective alternative to ERP (e.g., McLean et al., 2001; Öst et al., 2015; Ougrin, 2011; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008; Whittal, Thordarson, & McLean, 2005), though a recent study has shown faster symptom reduction with ERP than CT (Olatunji, Rosenfield, et al., 2013). Whereas there is a dearth of research investigating the question of whether adding cognitive strategies to ERP leads to improved outcomes compared to ERP alone, some recent research suggests that the addition of CT to ERP leads to medium to large symptom reductions at posttreatment and 6-month follow-up compared with ERP alone, following a 14-week protocol (Rector, Richter, Katz, & Leybman, 2019).

There is also emerging support for other psychosocial treatments. Acceptance and commitment therapy, which teaches clients to reduce maladaptive avoidance of obsessions through acceptance of intrusive thoughts,

as well as changing the relationship one has with unwanted thoughts, has been demonstrated to be an effective treatment for OCD (see Smith, Bluett, Lee, & Twohig, 2017, for a review). There is also support for other mindfulness and acceptance-based treatments for OCD (e.g., Key, Rowa, Bieling, McCabe, & Pawluk, 2017; Külz et al., 2019). Eye movement desensitization and reprocessing (EMDR) may be effective for OCD (Marsden, Lovell, Blore, Ali, & Delgadillo, 2018), though whether eye movements play a role in the effectiveness of EMDR requires further study. In addition to stand-alone treatments, adjunctive treatments, such as MI, may enhance the efficacy of ERP (McCabe et al., 2019). Last, transdiagnostic treatments are promising for OCD symptom reduction. Controlled trials of transdiagnostic treatments, including clients with OCD, have demonstrated improvements in clinical severity (e.g., Barlow et al., 2017), although outcomes were not broken down by disorder. In summary, there are a variety of cognitive and behavioral treatments that are likely to be effective for OCD.

Group Treatments

Although most studies of psychological treatments for OCD have been based on individual treatment protocols, a number of studies have found that OCD can be treated effectively in a group format (see Bulut & Subasi, 2020; Schwartze, Barkowski, Burlingame, Strauss, & Rosendahl, 2016, for a review). Group treatments that have been described in the literature include cognitive treatments (McLean et al., 2001), behavioral treatments (e.g., ERP; Fals-Stewart, Marks, & Schafer, 1993; Himle et al., 2001), treatments that combine ERP and CT (Belotto-Silva et al., 2012; Cordioli et al., 2003; Jónsson, Hougaard, & Bennedsen, 2011), groups for family members of individuals with OCD (Van Noppen, Steketee, McCorkle, & Pato, 1997), and support groups (e.g., Black & Blum, 1992).

Cordioli et al. (2003) demonstrated in a controlled study that the percentage of improved clients was 69.6% for those treated with 12-session group CBT and 4.2% in a wait-list control condition, providing evidence in support of group treatments. Himle and colleagues (2001) compared a seven-session group ERP treatment to a 12-session group ERP treatment and found both 2-hour groups to be equally effective. McLean et al. (2001) compared 12 sessions of 2.5-hour cognitive and behavioral group treatments for OCD. The percentage of individuals considered *recovered* at posttreatment was 16.0% in the CT group and 38.0% in the ERP group. At 3-month follow-up, the percentages were 13.0 and 45.0%, respectively, which represented a statistically significant difference. More recently, a controlled trial demonstrated that both group CBT and group metacognitive therapy were effective for OCD, with metacognitive therapy outperforming CBT (Papageorgiou et al., 2018).

There have also been preliminary reports on the effectiveness of group interventions for families of clients with OCD. A recent meta-analysis found

that group family-integrated CBT for OCD was effective for reducing adult OCD severity (Stewart, Sumantry, & Malivoire, 2020). For example, Van Noppen et al. (1997) compared two types of group treatment for OCD: one that included groups of six to eight clients on their own, and another that included groups of six to eight clients along with at least one family member each (usually a spouse or parent). Treatment consisted of 10–12 two-hour sessions. Both group formats led to comparable gains (with 70–80% of clients improving by at least 20% on symptom severity). Gains were at least as strong as those in previous studies based on individual therapy. Group therapy was associated with a low dropout rate and with relatively large treatment effects compared to those reported in previous individual treatment studies. Gomes et al. (2016) found that 12 two-hour sessions of family-integrated group CBT reduced OCD symptoms compared to a wait-list control.

A limited number of studies have compared individual and group treatment for OCD. For example, O'Connor et al. (2005) compared group and individual treatments for clients with OCD who had primarily obsessions without compulsions. The group treatment condition included four individual sessions, followed by 12 group sessions lasting 2 hours each. The individual treatment condition included 16 sessions (14 lasting 1 hour, and 2 lasting 90 minutes). Treatment in both conditions included psychoeducation, cognitive strategies, and ERP. Overall, both treatments were effective, though individual treatment produced the greatest changes in OCD symptoms, as well as anxiety and depression. The small number of therapy groups (a total of two), and the large size of each group (on average, 13 participants in each therapy group), may have accounted for the weaker effects of group treatment in this study. Follow-up findings were not presented. A meta-analysis by Eddy, Dutra, Bradley, and Westen (2004) found that individual therapy leads to larger changes than group treatment for OCD. Specifically, among those who completed treatment, a mean of 44% of clients (averaging across studies) who received individual therapy were considered recovered, compared to an average of 28% for those who received group treatment. These percentages as computed for all clients (based on "intent-to-treat" analyses that also included clients who did not complete treatment) were 37 and 22%, respectively.

Anderson and Rees (2007) compared the delivery of CBT for OCD individually or in a group. Individual CBT consisted of 10 sessions lasting 1 hour each. Group CBT consisted of 10 sessions that were 2 hours in length and were facilitated by two therapists. Both treatments were found to be effective. However, those receiving individual treatment showed a more rapid response to treatment, though by 10-week follow-up, participants across both treatments demonstrated equal rates of recovery. A meta-analysis by Olatunji, Davis, Powers, and Smits (2013) examining the efficacy of CBT for OCD showed no significant differences in effect size between group and individual treatment. In addition, a recent meta-analysis by Öst

et al. (2015) found there was no significant difference between group and individual treatment for OCD. Last, there appears to be no difference in dropout rates between group and individual treatments (Pozza & Dèttore, 2017). However, more studies comparing the effectiveness of group and individual treatment are required prior to making definitive conclusions about which approach is most effective.

Combining Pharmacological and Psychosocial Treatments

Though older research comparing ERP to pharmacotherapy has generally shown both approaches to be about equally effective (e.g., Abramowitz, 1997; van Balkom, van Oppen, Vermeulen, & van Dyck, 1994), a recent meta-analysis by Skapinakis et al. (2016) showed that psychosocial treatments (i.e., ERP, CT, and CBT) were more likely to lead to a larger effect, as measured by a reduction in mean self-reported symptom severity, than were medications. These findings have been supported by other more recent meta-analyses (Öst et al., 2015; Romanelli, Wu, Gamba, Mojtabai, & Segal, 2014). In addition, studies examining the combination of pharmacotherapy and psychological treatment (mostly ERP) have generally failed to find any advantage of combining treatments (see van Balkom & van Dyck, 1998; Öst et al., 2015, for reviews).

However, some studies have identified particular conditions under which combined treatments may be warranted. Hohagen et al. (1998) found that the combination of ERP and an SSRI was more effective than ERP alone for reducing obsessions (but not compulsions), and for clients who had depression along with their OCD. O'Connor, Todorov, Robillard, Borgeat, and Brault (1999) found that the combination of CBT and medication was more effective than either alone, particularly when the CBT was added after a period of medication use (rather than introducing both simultaneously). Finally, Kampman, Keijsers, Hoogduin, and Verbraak (2002) found that adding CBT can be useful for clients who do not respond to an SSRI alone. Relatedly, Skapinakis et al. (2016) showed that the combination of SSRIs or clomipramine with psychotherapy was useful for clients with severe OCD.

Assessment and Eligibility for Group CBT in OCD

A thorough discussion of issues related to the assessment of OCD is beyond the scope of this chapter. The reader is referred to Taylor, Abramowitz, McKay, and Garner (2020) for a detailed review. In addition, Rapp, Bergman, Piacentini, and McGuire (2016) reviewed the details on more than 20 different instruments (psychodiagnostic interviews, clinician-administered symptom severity scales, self-report measures, and parent/child measures).

In the context of group treatment for OCD, assessment has two main functions. First, a detailed assessment should be completed to indicate the degree to which the individual is suitable for group treatment. Second, appropriate measures should be used to assess treatment outcome. The issue of suitability for group treatment is discussed in various sections throughout the remainder of this chapter, including a review of recommended inclusion criteria for group treatment. Therefore, this section focuses more on measuring symptom severity before and after treatment.

Summerfeldt (2001) reviewed several obstacles in the assessment of OCD. These include comorbidity and symptom overlap (e.g., distinguishing between OCD and obsessive–compulsive personality disorder), heterogeneity of symptom content, upsetting or embarrassing symptom content (e.g., clients may be reluctant to admit to having sexual obsessions), symptom shifting over time, clinical features that affect response style (e.g., avoidance, need for exactness, doubt, obsessional slowness), and lack of insight. Because of these obstacles, it is important that the assessment take a multimodal format, including information from standard self-report and clinician-administered scales, behavioral assessments, and detailed interviews with clients and perhaps their family members.

With respect to standard scales, we recommend including the Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) second edition as part of the assessment battery (Storch et al., 2010). Ideally, the standard clinician-administered version should be used, though there is a self-report version that may be considered if therapist time constraints are a problem. The Y-BOCS provides not only detailed information regarding the breadth of symptom content but also information about other aspects of severity, including the time taken up by symptoms, distress, and functional impairment. In addition, one or two brief symptom measures may be useful for measuring initial severity and treatment outcome. In our work, we use the Obsessive–Compulsive Inventory—Revised (OCI-R; Foa et al., 2002)—a number of other options are available (see Rapp et al., 2016; Taylor et al., 2020, for reviews), including the Obsessional Beliefs Questionnaire (OBQ; Steketee & Frost, 2001).

Structuring Group CBT for OCD

The following section focuses on OCD-specific groups rather than the treatment of OCD within transdiagnostic groups.

Group Composition and Format

Table 7.1 provides details from several studies on group treatment for OCD that relate specifically to group composition and treatment format. In this section, we make specific recommendations based on existing research, as well as on our own clinical experience.

TABLE 7.1. Format and Composition for Group OCD Treatments

Study	Number of sessions	Group composition	Length of sessions	Strategies
Cordioli et al. (2002, 2003)	12 weekly sessions	8 clients, 2 therapists	2 hours	ERP, CT, group techniques
Fals-Stewart et al. (1993)	24 sessions over 12 weeks	10 clients	2 hours	ERP, imaginal exposure (when appropriate)
Himle et al. (2001)	7 or 12 weekly sessions	Not reported	2 hours	Behavior therapy
McLean et al. (2001)	12 weekly sessions	6–8 clients, 2 therapists	2.5 hours	ERP, CT, behavioral experiments
O'Connor et al. (2005)	16 sessions over 20 weeks	Mean of 13 clients (26 clients in two groups)	2 hours	ERP, CT
Anderson & Rees (2007)	10 weekly sessions	20 clients, 2 therapists	2 hours	ERP, CT
Jónsson et al. (2011)	15 weekly sessions; booster sessions at 1, 3, and 6 months	Not reported	2 hours	ERP, CT, behavioral experiments
Belotto-Silva et al. (2012)	12 weekly sessions	6–8 clients, 2 therapists	2 hours	ERP, CT
Hansen et al. (2018)	4 sessions over 4 days	3–6 patients, 3–6 therapists	3–10 hours	ERP
Papageorgiou et al. (2018)	12 weekly sessions	123 clients in CBT, 95 clients in MCT, 2 therapists per group	2 hours	CBT: ERP, CT; MCT: metacognitive therapy, mindfulness, exposure

Note. Neither Fals-Stewart et al. (1993), O'Connor et al. (2005), nor Jónsson et al. (2011) reported the number of therapists in each group. Himle et al. (2001) did not report the number of clients and the number of therapists in each group. Note that the treatments in many of these studies also included psychoeducation or relapse prevention strategies, though these are not included in the table. MCT = metacognitive therapy.

Number and Frequency of Sessions

The length of group treatments for OCD across research studies ranges from seven to 25 sessions, with an average of around 13 sessions (Whittal & McLean, 2002). The protocol described in this chapter is based on the treatment used in our clinic, which lasts 14 sessions (weekly at first, with the last two sessions occurring every other week). We recommend that

treatment typically last between 10 and 15 sessions. Most group treatment studies are based on weekly sessions. Though it is often most practical to schedule weekly sessions when working with groups, scheduling more frequent sessions may be useful, particularly early in treatment. Studies based on individual treatment protocols are often based on a more intensive schedule (e.g., several sessions per week), and some clients may do better when sessions are scheduled closer together.

Composition of Groups

OCD group treatment studies typically include six to 10 clients and two therapists. In our experience, the larger the group, the more likely participants are to feel inhibited socially, and early dropouts may be more likely to occur. Smaller groups also allow for more individual attention to participants' needs. An advantage of larger groups is that clients are more likely to have others in the group with similar symptom profiles. As we discuss later, symptom heterogeneity can be a problem in group treatments for OCD, and anything that can be done to help clients to not feel alone in the group is helpful.

Group treatment usually involves two therapists. One therapist takes a primary role in delivering the treatment, and the extent of the second therapist's involvement depends on their level of experience (because we are a training clinic, the second therapist is often a student). Including a third therapist can sometimes be useful for larger groups, especially when conducting in-session exposures. At our clinic, the third therapist is typically a more junior student whose main role is that of observer. Later in the treatment, when the group splits up for in-session exposures, the third therapist may play a more active role in coaching clients through their practices.

Inclusion Guidelines

Diagnosis and Clinical Severity

In our clinic's OCD groups, we require that OCD be the principal diagnosis of each participant. In other words, if multiple problems are present, we select for groups only participants for whom OCD is the most distressing or impairing problem. Finally, most research studies require that participants have clinically significant symptoms, based on a Y-BOCS score of at least 16. However, individuals with less severe symptoms may still benefit from group treatment.

Symptom Profile and Fit

Generally, the more homogeneous groups are with respect to symptom profile (e.g., sexual obsessions, contamination obsessions), the better. If group

members have different symptom profiles, they are less likely to see the similarities between their symptoms and those of others. In practice, it is often difficult to assemble homogeneous groups. Still, treating some clients individually may be worth considering if their symptoms are very different from those of other group members.

Comorbidity

Comorbidity is the norm in OCD, and most participants in group treatment have other difficulties in addition to just OCD. Depression and anxiety disorders are particularly common comorbid conditions. Generally, comorbidity should not be a rule out for group treatment. However, if a comorbid condition is likely to interfere significantly with a client's response to treatment, or with the response of other group members, the therapist should consider treating the client individually. For example, a client who has very severe depression, severe borderline personality disorder (BPD), or significant problems with substance dependence may be better treated individually than in a group format.

Insight

Although no data address the issue of whether individuals with poor insight should be treated individually or in groups, there are reasons to believe that both approaches may have benefits. Some clients with poor insight may respond best to individual treatment because it provides a better opportunity for more intensive therapy and to tailor the intervention to the individual's needs (individuals with poor insight often respond less well to treatment). In other cases, individuals with poor insight may benefit more from group treatment. Meeting others who have similar symptoms (except with more insight) may help individuals to recognize that their symptoms are excessive. The decision of whether to include a client with poor insight in a group treatment should be made on a case-by-case basis, taking these and other factors into account.

Client Motivation and Preferences

Some clients with low levels of motivation may not do as well in group treatments. In such cases, individual treatment may provide more opportunities for the therapist to target issues surrounding motivation more directly. The client's preference for group versus individual treatment should also be considered when deciding whether a particular individual is included in a group, though the therapist should recognize that individuals who are initially apprehensive about group treatment often still respond well in the end.

Interpersonal Skills

Individual treatment should be considered for clients who seem unlikely to be able to function effectively in a group (e.g., those who tend to be very hostile toward others). Clients who do not function well with other people may benefit less from group therapy and may also have a negative impact on the treatment response of other group members.

Structure of Group Sessions

Group sessions typically last between 2 and 2.5 hours. Sessions should begin with setting an agenda. The therapists should provide a brief overview of what is to be covered in the meeting, and participants should be given an opportunity to contribute to the agenda if there are specific issues they want to discuss. Next, homework is typically reviewed. Each participant is asked to take 5 or 10 minutes to discuss progress with homework and any issues that arose during the week. Therapists should decide whether to have clients hold on to their monitoring diaries during this part of the session (so clients can be prompted with respect to what happened during the week) or to have the therapist collect participants' diaries and monitoring forms (so that corrective feedback can be provided).

Part of the session may also be spent providing psychoeducation to group members. For example, in the early sessions, participants are provided with a rationale for the treatment and are taught various strategies for dealing with their OCD symptoms. In addition, once ERP has been introduced, part of each session is spent practicing exposure.

Finally, most sessions end with assignment of new homework, which typically involves assignments to practice ERP. In addition, participants are reminded to complete their monitoring diaries, as well as any recommended readings.

Key Treatment Components for OCD

This section provides an overview of the main components of CBT for the treatment of OCD, including psychoeducation, ERP, and CT. For readers seeking a more detailed description of these treatments, there are a number of excellet books that describe cognitive strategies (e.g., Wilhelm & Stetekee, 2006), exposure-based strategies (e.g., Foa, Yadin, & Lichner, 2012), and their combination (e.g., Bream, Challacombe, Palmer, & Salkovskis, 2017; Clark, 2020; Rego, 2016) for treating OCD. Table 7.2 provides a summary of what might be included in each session, based on standard CBT approaches to OCD treatment.

TABLE 7.2. Sample Outline of Treatment Protocol for Group CBT for OCD

Session	Strategies covered
Pretreatment individual meeting	• Explain how the group will work and what to expect. • Introduce norms and rules for the group and provide practical information (e.g., location and times for group). • Develop an exposure hierarchy. • Answer any questions and address concerns.
Session 1	• Introduction to group members (group members share experiences about what brought them to the group and describe OCD triggers and key symptoms). • Explain what to expect from treatment. • Review rules for the group (e.g., confidentiality). • Psychoeducation: model of OCD, define key terms, overview of treatment strategies, recommend self-help readings. • Discuss concerns around treatment and explore motivation for change. • Homework: Complete monitoring forms, read introductory chapters from self-help readings. • Discuss potential obstacles to completing homework.
Session 2	• Homework review. • Psychoeducation: Review cognitive model, introduce cognitive distortions. • Homework: Monitor cognitive distortions.
Session 3	• Homework review. • Psychoeducation: Review strategies for challenging cognitive distortions. • Homework: Practice challenging cognitive distortions on thought records.
Session 4	• Homework review. • Psychoeducation: introduction to exposure and ritual prevention. In-session exposures and ritual prevention. • Homework: cognitive restructuring, completion of thought records, exposure practices, and prevention of rituals.
Sessions 5–13	• Homework review. • In-session exposures and ritual prevention. • Homework: cognitive restructuring, completion of thought records, exposure practices, and prevention of rituals.
Session 14	• Homework review. • Psychoeducation: Discuss triggers for relapse and recurrence, review strategies for preventing relapse and recurrence. • Homework: Practice relapse prevention strategies.

Psychoeducation

CBT is very much a skills-based approach to treatment, and psychoeducation is almost always included as a component of CBT. In the context of group treatment for OCD, education may occur in the form of didactic presentations, facilitated discussion among group members, demonstrations, assigned readings, or video presentations. Examples of education topics that are often included are as follows:

- Information about the nature and treatment of OCD.
- Guidelines for conducting ERP.
- Theories regarding the causes of OCD.
- CBT models of OCD.
- Information regarding the impact of OCD on the family.
- Family factors that can influence treatment.
- Making lifestyle changes (e.g., diet, exercise, sleep habits).
- Strategies for improving quality of life (e.g., employment, relationships).

Some of these topics (e.g., CBT models of OCD, causes of OCD) are routinely covered at the beginning of treatment. Others (e.g., lifestyle issues) may be covered later.

Exposure

Exposure to feared situations is believed by many experts to be an important, if not essential, component of treatment for phobic disorder and OCD. Hundreds of studies have demonstrated that exposure consistently leads to a reduction in fear, and much is known about the variables that influence the outcome of exposure-based treatments. In the case of OCD, prevention of the compulsive rituals (discussed after this section on exposure) is an important component of any exposure-based treatment.

Because of the wide range of fear triggers that occur in clients with OCD, it is often impossible to generate exposure ideas that are relevant to all group members. Therefore, during in-session exposures, groups are typically divided up, and members practice exposure either in smaller groups or individually. For example, two members may practice touching contaminated objects (e.g., elevator buttons, money, doorknobs), while another practices writing a letter that contains spelling errors.

Exposure practices may occur in the same room as the group sessions, or group members may leave the room to practice elsewhere, depending on the situations that tend to trigger their obsessions and fear. Therapists typically move around the room to check on clients' progress. In some cases, one therapist may accompany one or more clients on an exposure excursion

(e.g., going for a drive with an individual who is fearful of hitting pedestrians while driving), while the other therapist(s) stay behind to work with the remaining clients.

Before exposure begins, it is important to present the rationale for the procedures in a coherent and convincing way. Clients are asked to make a commitment to conduct exposure practices despite feeling uncomfortable and frightened. A model is presented to explain how exposure works, and clients are taught about the best ways to implement exposure practices. Chapter 3 reviews the most important guidelines for maximizing the benefits of exposure. As a reminder, exposure practices should be predictable, controllable, prolonged, and frequent. Clients should not distract themselves during exposures, and the use of safety behaviors should be minimized. The context of the exposure, as well as the types of stimuli used, should be varied. For example, a person who is fearful of becoming contaminated by certain foods should practice eating a wide range of feared foods, in a wide variety of contexts (e.g., at home, in restaurants, in friends' homes). Finally, clients should be encouraged to take steps as quickly as they are willing to progress. The sooner they move on to more difficult practices, the more quickly they see a reduction in the impact of their OCD.

In vivo (i.e., situational) exposure is most appropriate for individuals who are fearful of particular situations, places, objects, or activities. Examples include obsessions about contamination, losing things, and making minor mistakes. Exposure in imagination is most appropriate for clients who are frightened of experiencing particular images or thoughts (e.g., religious, sexual, and aggressive obsessions). Often, a combination of imaginal and *in vivo* exposure can be useful. Table 7.3 provides examples of exposure practices for a wide range of OCD presentations.

Developing an Exposure Hierarchy

In Chapter 3, we review the process of developing an exposure hierarchy. In OCD, it is not unusual for individuals to have a wide range of situations that trigger anxiety or lead to avoidance. In such cases, it can be helpful to generate more than one hierarchy. For example, a client with obsessions concerning contamination, as well as aggressive impulses, could have a separate hierarchy for each of these two domains. For another client (e.g., one who experiences different symptoms at home and at work), it may make sense to have one hierarchy for work-related symptoms and another for home-related symptoms. Hierarchies can be generated collaboratively between the client and therapist in an individual meeting that occurs before the group begins. However, it is also fine to spend time in the group teaching participants to develop their hierarchies, having them generate hierarchy items as a homework assignment, then providing feedback on hierarchies at the next session.

TABLE 7.3. Sample Exposure Practices for Particular OCD Presentations

OCD presentation	Examples of ERP practices
Contamination obsessions and excessive washing	• Touch contaminated objects for an extended period (e.g., rub the object over one's hands and face). • Touch food (e.g., a candy) to a contaminated object and then eat it. • Set a timer in the bathroom to ensure that showers last no more than 5 minutes. • Turn off the main water source in the basement, so water is not available for washing. • Contaminate everything in the home.
Fear of particular words or images (e.g., religious symbols, colors, numbers, names)	• Stare at the feared word or image. • Repeat feared words or phrases out loud. • Bring a feared image to mind and keep it there for an extended period. • Write out feared words and phrases. • Describe a feared image in detail, either out loud or in writing.
Fear of running over pedestrians	• Drive on bumpy roads. • Describe an image out loud, or in writing, of having hit a pedestrian while driving. • Do not check for bodies after hitting a bump or experiencing a thought of having hit someone. • Avoid watching the news or listening to accident reports (if one's natural inclination is to engage in these activities excessively). • Purposely watch the news or listen to accident reports (if one's natural inclination is to avoid these activities).
Aggressive or sexual obsessions	• For fear of stabbing a loved one, practice handling knives and other sharp objects with loved ones in the room; describe out loud, or in writing, images of stabbing a loved one. • Consider imaginal exposure to images of hurting a loved one. • Be around children (e.g., change one's baby) despite irrational intrusive thoughts of harming children sexually. • For intrusive thoughts involving doubt about one's sexual orientation, practice looking at photos of same-sex individuals, change in a public changing room, and so forth.
Need to repeat actions	• Prevent oneself from repeating actions (e.g., leave the situation before having the opportunity to repeat). • If activities have to be repeated a certain number of times or in a specific way, try repeating them in the wrong way for the wrong number of times.
Need to check one's work (e.g., writing)	• Prevent oneself from checking work. • Purposely make mistakes in one's work (but not mistakes that will lead to serious consequences).

(continued)

TABLE 7.3. *(continued)*

OCD presentation	Examples of ERP practices
Compulsive reassurance seeking	• Instruct family members and other sources of reassurance not to provide reassurance anymore (they can reassure the client that the anxiety will decrease over time, but they should not reassure the client about the content of the obsessions). • Tolerate discomfort without asking for reassurance. • Practice imaginal exposure to feared images that trigger the desire to obtain reassurance.
Perfectionism	• Purposely make minor mistakes that trigger anxiety (e.g., pronounce words incorrectly, fold the towels incorrectly, make spelling errors). • Encourage others to make minor mistakes that trigger one's anxiety.

Figure 7.1 provides an example of an exposure hierarchy for an individual who is fearful of encountering objects, situations, or words having to do with the occult, the devil, or other related constructs. As reviewed in Chapter 3, an exposure hierarchy should contain 10–15 items. Items should be as detailed as possible, specifying variables that influence the person's fear. In the case of OCD, hierarchy items and their ratings should include (either explicitly or implicitly) an assumption that the exposure to the item will not be followed by a compulsion.

Ritual Prevention

Complete versus Partial Ritual Prevention

As reviewed earlier, ERP appears to work best when strict ritual prevention instructions are given. In other words, it is best to prevent all rituals rather than to implement ritual prevention in a gradual or partial way. For example, in some intensive treatment programs (e.g., inpatient treatment, day treatment), clients are asked to stop all washing except for a brief shower once per week. In outpatient programs, including most group treatment programs, such restrictions may be impractical, but it is still preferable to eliminate all rituals where possible, and to reduce the frequency of normal behaviors that are similar to the compulsion. For example, for someone who washes excessively, a 5-minute shower every day or every other day may be permitted, but all other washing should still be discouraged. If eliminating all compulsion-like behaviors is dangerous, then the goal should be to decrease the frequency of the behaviors as much as possible. For example, a pharmacist who is afraid of giving customers the wrong medications should be encouraged to check once or twice, if that is the standard of practice, but should be discouraged from excessive checking.

Name: _____ Session: Pretreatment Date: _____

Item	Fear (0–100)	Avoidance (0–100)
1. Go out without Ativan.	100	100
2. Go to the movies and sit in the middle of the row.	100	100
3. Stay alone at home in the morning.	99	100
4. Drive to the city alone.	95	90
5. Go to the mall when crowded.	90	80
6. Go out without a cell phone.	80	80
7. Drive on the highway alone outside of the safe zone.	80	60
8. Go to the gym.	70	90
9. Drive to the city as a passenger.	70	40
10. Go to the mall when it is uncrowded.	70	0
11. Go to the movies and sit on the aisle.	60	100
12. Wait in a line.	50	0

FIGURE 7.1. Sample exposure hierarchy with initial ratings.

Presenting the Rationale for Ritual Prevention

Clients should understand that using compulsions to decrease their fear undermines the effects of exposure. The purpose of exposure is to teach the individual that feared objects, situations, thoughts, and images are in fact safe. When clients use compulsions, they are likely to attribute any positive outcomes to the fact that they engaged in a ritual, rather than to the idea that there was no risk in the first place. There are a number of analogies that therapists sometimes use to make this point.

First, OCD can be compared to a car, and rituals to gasoline. When an individual completes a ritual, it is comparable to putting gas into a car.

Compulsions keep the OCD alive. It is not until we allow the car to run out of gas that it finally stops running. The same is true of OCD. It is not until rituals are completely prevented that the OCD symptoms die. Even occasional rituals may be enough to keep the OCD alive.

Another analogy involves comparing OCD to a spoiled child, and comparing compulsions to the act of giving in to the child (e.g., giving the child candy when they throw a tantrum). When a parent gives in to the child, the child learns that throwing a tantrum is a way to get what they want. If a parent does not give in, the child has an opportunity to learn that using temper tantrums does not result in getting their way. The same is true of OCD. When rituals are stopped, the anxiety will eventually burn itself out, and the urge to do the ritual will die down, as well.

Dealing with Resistance

It is not unusual for clients to express apprehension about stopping all rituals. If this occurs, the therapist should try to alleviate the concerns by helping the individual to look at the situation in as balanced and realistic a way possible (e.g., using cognitive strategies). In addition, the client should be reassured that the therapist will be there for support. In addition to the weekly group meetings, some clients may need extra support by phone or through additional, individual sessions. Group members may also be able to support one another between sessions (e.g., it is not unusual for group members to exchange phone numbers). Clients should also be encouraged to rely on family members for support. At moments when the urge to do the ritual is overwhelming, clients should be encouraged to do whatever they can to prevent the ritual (go for a walk, get away from the situation, talk to a close friend, etc.). Although distraction is generally discouraged during exposure practices, it is preferable to distract oneself than to do the ritual. MI strategies are effective when implemented in the context of CBT (McCabe et al., 2019). For example, it may be of benefit to have clients complete a decisional balance worksheet in session, where they can reflect on the pros and cons of stopping rituals. Harnessing client values may help clients focus on reasons to change (e.g., being able to spend more time with their children if they reduced rituals).

If clients cannot commit to preventing their rituals, there are a few options to consider. One option is to have clients agree to delay their rituals. A client who can delay a ritual for 15 minutes and then reevaluate the situation may find that they can then delay the ritual for another 15 minutes, and so on. Sometimes, agreeing to delay the ritual for 15 minutes at a time, until the urge finally subsides, is more tolerable than the thought of promising to not do the ritual at all. Clients may also be willing to eliminate only some rituals (e.g., washing but not checking, home rituals but not work rituals, evening rituals but not daytime rituals), at least to start. If the most a client will agree to do is eliminate rituals partially, it is better to

tie the decision of which rituals to eliminate to factors such as the type of ritual, the location, or the time, rather than tying the decision to the severity of the person's anxiety or urge to do the compulsion.

Eliminating Cognitive Rituals

In addition to eliminating overt rituals, cognitive rituals should be circumvented. For example, if a client tends to count in 3s, they should be encouraged to stop counting. If necessary, the client can be encouraged to perform a behavior that competes with the cognitive ritual (e.g., counting in 2s) temporarily, but the therapist should be vigilant for the possibility that the competing behavior can itself become a ritual.

Undoing the Effects of Rituals

If the client cannot resist the urge to do the compulsion, they should be encouraged to undo the effects of the compulsion by engaging in additional exposure. For example, after a shower, clients should make an effort to come into contact with contaminated objects. In addition, a number of strategies can be used to circumvent the urge to do the compulsion. For example, eating a candy that has come into contact with contamination may help to prevent the urge to wash (there is no point in washing if the contamination has already been taken into the body). Similarly, purposely making mistakes in a letter and then mailing it may circumvent urges to check the letter for mistakes.

Cognitive Strategies

There are cases in which cognitive strategies should be used with caution. First, cognitive restructuring may function for the client as a form of reassurance. If the client's compulsions include reassurance seeking, some types of cognitive restructuring may serve to maintain the need for reassurance. Second, some clients tend to think in a very detailed, compulsive way, and they sometimes get "lost" in their thoughts (ruminating about a wide range of thoughts that enter their heads). For these clients, cognitive restructuring may simply be impossible, and the most effective way to change their beliefs may be through less cognitive means, such as ERP alone.

Despite these issues, evidence has emerged in recent years that cognitive strategies can be useful for the treatment of OCD. CT emphasizes strategies such as normalizing intrusive thoughts, correcting faulty appraisals, generating alternative beliefs, examining the evidence for particular beliefs (e.g., beliefs concerning responsibility), preventing efforts to neutralize intrusive thoughts, and testing beliefs through behavioral experiments. In addition, CT for OCD often emphasizes changing metacognitive beliefs (i.e., beliefs about obsessions), such as the belief that one's intrusive

thoughts are dangerous and should be controlled, as well as beliefs about the overimportance of one's thoughts. In general, the intrusive thoughts themselves are not challenged directly.

When using cognitive strategies in groups, it is useful to have members of the group help one another with the process of cognitive restructuring. For example, all members of the group can be invited to generate alternative beliefs to challenge a particular group member's intrusive thought. Group members can also be encouraged to role-play how a therapist might respond to a particular concern raised by a client in the group. By helping clients to develop their skills at challenging one another's intrusive thoughts, they may become better able to apply the skills to their own obsessions.

Sample CBT Group Protocol for OCD

This 14-session group treatment protocol borrows from a number of standard treatments for OCD (e.g., Clark, 2020; Rego, 2016; Yadin, Foa, & Lichner, 2012a). The first 12 sessions occur weekly, and the last two sessions, every other week. After a thorough assessment, and before the treatment begins, each client meets individually with one or more of the group therapists to provide an opportunity for the client to have any concerns or questions addressed and to develop an exposure hierarchy. Therapy begins with presenting the rationale for treatment, which is mostly based on an ERP model. In addition, some sessions emphasize cognitive strategies. All sessions last 2 hours. The content of each session is summarized in Table 7.2.

Pretreatment Individual Meetings with Group Members

This session involves an individual meeting between one client and one or more of the group therapists. In this session, a basic introduction to the group is presented, including the group schedule (location, times, and dates), a brief overview of what will occur during the group sessions, the importance of maintaining confidentiality, the importance of regular attendance, and expectations regarding homework. Clients are given an opportunity to ask questions and to have their concerns addressed. Next, an exposure hierarchy is generated using items previously endorsed on the Y-BOCS, as well as any feared objects or situations mentioned by the client during the appointment.

Session 1: Presenting the Treatment Rationale

This session has several purposes. First, it is an opportunity to introduce group members and therapists to one another. In addition, ground rules for the group are reviewed to remind participants of some of the issues raised during the pretreatment meeting. Clients are provided with a model

of OCD and an overview of the treatment strategies. Possible obstacles to improvement, and ways of overcoming these obstacles, are discussed. Homework for the first session typically involves reading introductory chapters from an ERP-based self-help book (e.g., Abramowitz, 2018; Yadin, Foa, & Lincher, 2012b). Components of the first session are as follows:

1. Introduction of group members and therapists.
2. Group rules and overview: confidentiality, group structure, importance of regular attendance, expectations regarding homework (60–90 minutes per day), importance of being honest about symptoms and completed homework, reminder to have realistic expectations, reminder to expect treatment initially to cause increased discomfort.
3. Definitions of key terms: "obsessions," "compulsions," "OCD," "cognitive rituals," "cues," "triggers," "avoidance," and "neutralization."
4. Presentation of the cognitive-behavioral model of OCD, including the effects of compulsions and neutralizing on maintaining obsessions over time.
5. Having each client review their key obsessions and compulsions, followed by discussion to ensure that all group members understand how their symptoms fit into an OCD profile, which of their symptoms are obsessions, and which are compulsions (including mental rituals).
6. Discussion of treatment procedures, including cognitive strategies, exposure, and ritual prevention.
7. Discussion about the role of the family, including ways in which family members may be able to help (stopping accommodation, being supportive, being present during homework practices, etc.).
8. Discussion about the costs and benefits of overcoming the problem, as well as obstacles that clients expect to encounter over the course of treatment.
9. Homework: introductory readings on the CBT model and on an overview of treatment strategies.

Sessions 2 and 3: Cognitive Strategies

Session 2 begins with a discussion of the readings from the previous week. Next, the cognitive model for OCD is reviewed. During Sessions 2 and 3, participants are taught to identify examples of anxious thinking (e.g., TAF), and strategies for combating cognitive distortions are presented. Clients are instructed in how to complete cognitive monitoring forms. Homework includes challenging intrusive thoughts (e.g., examining the evidence, conducting behavioral experiments) over the next week rather than neutralizing or suppressing unwanted thoughts. In addition,

participants are encouraged to complete self-help readings related to the cognitive strategies.

Session 4: Introducing ERP

The first 45 minutes of this session are spent reviewing cognitive monitoring forms from the previous week. The rationale for ERP is then presented and guidelines for exposure are reviewed (e.g., the need for exposure practices to be predictable, prolonged, and frequent). Clients are instructed in how to use exposure monitoring forms. They are also encouraged to stop their rituals immediately. Strategies for dealing with intense urges to engage in compulsions are discussed. In addition to continuing to complete cognitive monitoring records, clients are encouraged to engage in at least 1 hour of exposure per day over the coming week, starting with an item from the bottom half of their hierarchy. They are also encouraged to complete self-help readings on ERP.

Sessions 5–13: In-Session Exposures

Each session begins with a review of homework, lasting about 45 minutes. During the homework review, the therapists take advantage of any opportunities to challenge anxious appraisals that arise. The next hour is spent on in-session exposures, individually tailored to the clients in the group. The final 15 minutes are spent assigning homework for the next week, including exposure to feared situations, objects, and images; prevention of rituals; and cognitive restructuring. Throughout treatment, clients should be vigilant for any new rituals that emerge, as well as any new avoidance behaviors.

Session 14: Termination and Relapse Prevention

After a review of the homework, issues related to relapse and recurrence are discussed. Participants are reminded that the severity of OCD normally fluctuates over time. They are encouraged to tolerate periods of increased severity, without falling back into old habits of avoidance and rituals. Instead, they should engage in occasional exposures to help maintain their gains. Being vigilant for possible triggers of recurrence, including increased life stress, helps to alert clients to the possibility of symptoms worsening, so they can be better prepared.

Posttreatment Evaluation

Clients are invited to complete a posttreatment evaluation. At this stage, the main outcome measures are repeated. Clients who require additional treatment may be offered a series of individual sessions, pharmacotherapy,

family sessions, self-help interventions, support groups, or other interventions, depending on their needs and preferences. In addition, we offer all clients the opportunity to participate in a monthly booster group designed to help previously treated clients at our clinic maintain their improvements.

Variations on the Protocol

There are a number of ways in which this protocol can be modified. First, there are data supporting group treatments of longer (e.g., 25 sessions) and shorter (e.g., seven sessions) durations. The length of each session can also be extended (e.g., some clinics have group sessions lasting 2.5 hours). Session frequency can be altered as well. Although we recommend against meeting less often than once per week, there may be benefits of increasing the frequency of meetings to more than once per week. If possible, including family members (e.g., a spouse or parent) in one or more sessions may be useful, particularly for clients who report that their family members "don't understand," or in cases where family members engage in counterproductive behaviors, such as accommodation. Finally, if practical, there may be cases in which group and individual treatments can be combined. For example, it is possible to deliver the early sessions (e.g., psychoeducation, CT) in a group format, and the later sessions (e.g., exposure) in an individual format.

Advantages of Treating OCD in Groups

Group treatments are often more cost-effective than individual treatments. They take up less therapist time (on a per-client basis), and the reduced cost per session is often passed on to the client. Group treatment is particularly useful in settings where the number of client referrals is simply too large to manage on an individual basis. However, the benefits of group treatment are not simply financial. There are many other benefits to clients, some of which are difficult to measure objectively.

Clients often describe a sense of relief when they discover that they are not alone. They often say that it is very comforting to meet others with OCD and to discover that they seem so "normal." This helps clients realize that to the average person, an individual with OCD would probably not stand out as being unusual in any way. It also helps them to be less embarrassed and secretive with respect to their own symptoms.

In most cases, clients tend to be very supportive of one another during the course of group treatment. For example, they are empathic when a client is discussing painful symptoms, and they may express worry about a client who does not show up for a given treatment session. When group

cohesion is strong, clients may exchange phone numbers and develop lasting friendships with other group members. It is not unusual for some clients to get together between treatment sessions and to do their homework together. Group members often value suggestions and feedback received from other group members, whose personal experience with OCD gives them a special ability to empathize with clients' symptoms.

Overall, group members should be encouraged to participate in group discussions and to share their experiences. In addition, it is often useful for participants to take a more active role in one another's treatment, as they become more familiar with the strategies. For example, group members can help with the process of cognitive restructuring and may suggest to one another exposure practices that might be completed for homework.

Group Process Factors in CBT for OCD

Heterogeneity in Group Membership

OCD is a heterogeneous condition, and clients often present with very different symptom profiles. For example, an individual who is fearful of contamination may seem to have little in common with an individual who is constantly thinking about stabbing family members. Heterogeneity among group members can lead to a number of different problems. First, clients who feel different from other group members or whose symptoms are more "socially unacceptable" may be reluctant to discuss their symptoms in front of the group. In fact, they may refuse group treatment completely. This is particularly a problem for individuals who have aggressive, religious, or sexual obsessions. Therefore, it is useful to have more than one person in each group with these kinds of thoughts. Second, clients sometimes trivialize the concerns of others. For example, a client might say, "I wish my fear was just of making mistakes at work. I could live with that! My fear of killing my children is much more of a problem." Finally, some clients may not be understanding or supportive toward the other group members. They may give others strange looks or make insensitive comments.

To deal with these issues, it is important early in treatment to educate the group about the various ways in which OCD symptoms are expressed. Right from the start, therapists should emphasize the commonalities across OCD presentations, particularly with respect to the cognitive and behavioral influences. Clients should also be reminded that the distress and impairment associated with OCD can be severe, regardless of the specific symptom profile, and that it is important for group members to be supportive.

A final issue to keep in mind is that because clients tend to have different symptom profiles, parts of the group necessarily have an individualized focus. For example, during exposure practices, clients may end up working on their own.

Symptom "Contagion" among Group Members

Clients who receive group treatment for OCD are often concerned about "catching" OCD symptoms from other group members. In reality, this is something that we have never actually seen occur. What may happen, however, is a tendency for some clients to reinforce avoidance behaviors in others. For example, some clients may suggest ways in which others can neutralize their obsessions (e.g., suggesting a new cleaning product to an individual with contamination concerns). People may also share information that strengthens one another's beliefs about the feared situations (e.g., sharing a story about a friend of a cousin who became ill by forgetting to wash her hands after handling raw chicken). However, after participants have become more familiar with the treatment rationale, they learn to stop encouraging one another's avoidance. With corrective feedback, this issue can usually be dealt with early in treatment.

Other Disadvantages of Group Treatment

A number of other problems may arise during the course of group treatment. First, clients who are progressing more slowly than others may become discouraged and drop out of treatment prematurely. Also, a group format minimizes the amount of individualized attention that each client receives. As a result, some participants end up having to listen to discussions that are not relevant to their own situations. Others may not receive as much individual attention as they need. In these cases, having the client attend a few individual sessions, in addition to the group, may be useful, if it is practical and the individual can afford it.

Other Special Considerations in Treating OCD

Although the focus of this chapter is on group treatment, there are a number of obstacles and special considerations that often arise while treating OCD either in groups or individually. Although these obstacles are not unique to group treatment, they often arise when providing treatment in groups, so they are discussed briefly in this section.

Breadth of Symptoms

Data from our clinic (Antony, Downie, et al., 1998) suggest that most people with OCD experience obsessions and compulsions of more than one type (washing, checking, repeating, etc.). A challenge that often confronts therapists is how to decide which symptoms to focus on first. Generally, this decision should be made after considering which symptoms cause the most distress and impairment, and which symptoms the client is interested in working on first. In selecting symptoms to work on, it is useful to consider

obsessions (i.e., intrusive thoughts), compulsions (including overt behaviors and mental compulsions), and avoidance behaviors. It is often not practical to have the client work on all symptoms at the same time. Rather, selecting those problems that are most important to overcome first may be a more useful approach.

Symptom Shift

In addition to having a wide range of symptom types at any given time, some clients with OCD report having symptoms that shift from one type to another over time. In some cases, symptoms may change over the course of months or years. However, in other cases, shifts may occur on a daily or weekly basis. For example, an individual may report being concerned about contamination one week, and then return the next week and explain that the exposure homework assigned was not relevant because contamination concerns were no longer an issue. Instead, during the previous week, the obsessions might have shifted to a focus on appliances being left on, for example. In such cases, the symptoms may seem like a moving target, and it may be difficult to find appropriate strategies to deal with them. For clients whose symptoms shift over time, it is especially important for them to understand the general principles of treatment and how they apply to a wide range of symptoms. In addition, clients may have to adapt planned homework practices to deal with new symptoms as they emerge.

Noncompliance with Exposure Homework

Antony and Swinson (2000) reviewed the following possible reasons why clients may not complete their exposure homework assignments: (1) not understanding the assignment, (2) not understanding the relevance of the assignment to their goals, (3) homework assignments that are too difficult, (4) other demands on clients' time (e.g., young children to take care of, busy work schedule), and (5) the therapist not checking on homework at the start of each session. To improve compliance, it is important to identify the factors that interfere with completion of homework for each client in the group for whom noncompliance is an issue.

Depending on the reason for noncompliance, some strategies for improving compliance include (1) making sure that the homework is explained in detail and that the instructions are written down by the client; (2) ensuring that homework practices are relevant to the individual's goals; (3) simplifying the homework task; (4) encouraging the client to try something easier, if a particular task is too frightening; (5) arranging for telephone contact or additional individual sessions between group meetings; (6) identifying family factors that may be contributing to noncompliance, or factors that may improve compliance (e.g., including family members in the practice); (7) trying the homework practice in the session

before assigning it for homework; (8) encouraging the client to schedule the practice in their calendar, so it is not forgotten; and (9) suggesting that the client find ways to manage other demands, in order to make time for the homework (e.g., taking a day off of work to engage in a prolonged exposure (PE) practice, or hiring a babysitter, so the children do not disrupt the homework session).

Transfer of Responsibility

Occasionally, clients will transfer responsibility to the therapist, which can undermine the effects of exposure. In these cases, it is important to transfer responsibility back to the client. Consider the following dialogue as an example of how this can be accomplished:

> Client: The thought of making mistakes at work over the coming week doesn't bother me. Because you asked me to do it for homework, you will be responsible if anything happens.
>
> Therapist: Because it is so frightening for you to feel responsible for the possibility of doing harm to someone else, it is important that you take responsibility for what happens during your exposure practices. Although I was the one to recommend this practice, ultimately you need to take responsibility for deciding whether to follow my recommendation.
>
> Client: Even so, I don't feel responsible, because you made the suggestion. Because we spoke about doing this, I feel like you will be responsible if something happens, so it doesn't really scare me.
>
> Therapist: In that case, perhaps we should try things differently this week. I would like you to come up with your own homework practice, but not tell me what it is until next week, after you have done it.
>
> Client: Now, that's something that I'm pretty sure will make me anxious. I don't want to do it, but it sounds like it may be helpful.

Issues Surrounding Religion

The literature has generally demonstrated that although religious individuals with OCD may experience more religious obsessions than nonreligious individuals with OCD, religion is not a risk factor for OCD more broadly (Siev, Huppert, & Zuckerman, 2017). However, more recent research has demonstrated that a religious crisis (defined as feeling disconnected from God or one's religious community) is associated with OCD-related beliefs, such as TAF and scrupulosity (a pathological fear of God and sin; Henderson et al., 2020). Interestingly, *spirituality,* which is not necessarily tied to religious observation or practice, is negatively associated with OCD

symptom severity in clinical samples and may buffer against risk factors for OCD (Henderson et al., 2020).

Overall, working with scrupulosity may require adaptations to the delivery of CBT (see Siev et al., 2017). One issue that sometimes arises when treating clients with OCD whose obsessions are primarily of a religious nature is trying to distinguish between religious beliefs that are simply part of the person's religion and those that are best conceptualized as part of the OCD. For example, clients with religious obsessions are usually uncomfortable with the suggestion that they expose themselves to frightening thoughts of a religious nature (e.g., "I am Satan"), but it may be difficult for them to know whether it is their OCD that makes them uncomfortable or their religious convictions. In such cases, it may be useful for clients to consult with family members or their religious leader to see which of their intrusive thoughts and compulsive behaviors are excessive in the context of their religion. Getting "permission" to participate in the treatment assignments can also be helpful in some cases. For example, obtaining reassurance from a minister, priest, rabbi, or other leader that it is okay to complete exposure practices can help a client to move forward with the treatment.

Effects of Functional Impairment

OCD is associated with impairment in a wide range of functional domains, including relationships, work, and quality of life (see Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009). For most clients, overcoming OCD leads to improvement in functioning across the board. However, for others, functional impairment may need to be targeted as a separate issue. For example, a client who has had OCD for many years, and who has therefore never worked or been in a long-term relationship, may feel overwhelmed as their OCD improves and these other issues move to the forefront. In these cases, it is important to work with clients on overcoming some of the obstacles to improving their quality of life (e.g., obtaining relevant job skills, expanding social networks). Group therapy for OCD may not be the best place to deal with these issues, if they are relevant to only one or two clients in the group. If that is the case, it may be more appropriate to provide some individual sessions to address these broader concerns.

Family Issues

Often family members do things that make it easier for the client to engage in rituals or to avoid feared situations. Such behaviors are often referred to as "accommodation," and they may help to maintain an individual's OCD symptoms over the long term. In a study by Albert and colleagues (2009), family members of individuals with OCD reported a wide range of accommodation behaviors, including participating in rituals, providing

reassurance, and helping the client to avoid feared situations (occurring on a daily basis in 47, 35, and 43% of family members, respectively).

It is often useful to include family members of clients with OCD in the treatment. This can be accomplished in a number of ways. For example, family members of clients can be invited to attend one or more sessions (either with the entire group, or for individual meetings including just the therapist, the client, and one or more family members). Alternatively, if family sessions are not feasible, clients should be encouraged to share treatment guidelines with their families and to have their families complete relevant self-help readings on OCD. Clients will likely do better in treatment if their family members have a good understanding of the nature and treatment of OCD, are provided with instructions not to reinforce OCD behaviors, and are given skills for interacting with the client around issues concerning the OCD (see Turner, Krebs, & Destro, 2017, for a review of family issues in the treatment of OCD).

Conclusions

OCD is a heterogeneous condition associated with a wide range of cognitive and behavioral features. Extensive research supports pharmacological interventions, as well as CBT-based treatments. From a psychological perspective, OCD is believed to stem from a tendency to misinterpret situations, objects, and one's intrusive thoughts as dangerous. CBT aims to shift anxious thinking through a number of behavioral and cognitive means. Although OCD is usually treated individually, several studies have shown that group treatment can be effective for this problem. Treating OCD in groups is associated with unique challenges, but it also has a number of advantages over individual treatment. This chapter provided an overview of strategies for treating OCD in a group format.

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