Cognitive Behavioral Treatment of Obsessive-Compulsive Disorders: A Commentary

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This commentary discusses a number of issues that arise from the papers published in this special issue on cognitive behavioral treatment (CBT) of obsessive-compulsive disorders (OCD). The reasons for the recent shift toward a more cognitive perspective in the theory and treatment of OCD are discussed. A theoretical framework is proposed for understanding the concepts found in various cognitive theories of OCD. Furthermore, the common, core ingredients of CBT for obsessive and compulsive problems are presented. The pitfalls and difficulties encountered by the clinician who offers CBT to individuals with OCD are discussed, and I conclude with a comment on the empirical status of the therapy.

Obsessive-compulsive disorders (OCD) are a group of anxiety disorders that can take a chronic and debilitating course with 1-year prevalence rates reported as high as 2.1% for the general population (Regier et al., 1993), although Antony, Downie, and Swinson (1998) question whether this estimate is too high because structured interviews, like the Diagnostic Interview Schedule, produce more false positives when diagnosing OCD. The distinguishing diagnostic criteria for OCD is the presence of obsessions and/or compulsions that cause significant distress or impairment in functioning (American Psychiatric Association, 1994). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), obsessions are “persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress” (p. 418), whereas compulsions are “repetitive behaviors or mental acts, the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification” (p. 418). Typical examples of obsessions are unwanted, intrusive and egodystonic (i.e., uncharacteristic of the person) thoughts, images, or impulses involving themes of dirt, contamination, sex, accidents, aggression, dishonesty, blasphemy, and the like. Compulsions typically involve some ritualistic behavior such as washing, checking, ordering, or hoarding. Earlier behavioral theories of OCD viewed obsessions as noxious conditioned stimuli that elicit a significant degree of anxiety or distress, with compulsions serving as strategies for reducing or neutralizing the anxiety caused by the occurrence of the obsession (Rachman & Hodgson, 1980).

In the 1970s a behavioral treatment of OCD was developed based on this early learning model of obsessions and compulsions. The treatment involved systematic exposure to the obsessions and any stimuli that would evoke them, as well as prevention of any compulsive or neutralizing behaviors that might be used to reduce anxiety. The central tenet of exposure and response prevention (ERP) treatment was that anxiety caused by the obsession would naturally habituate and so the frequency of the obsession and associated compulsive ritual would significantly decline with repeated exposure to the fear stimulus (i.e., obsession). ERP did prove to be a very successful form of treatment for OCD, especially for those with washing and, to a lesser extent, checking rituals. Outcome studies of ERP indicate that approximately 70% to 80% of OCD patients who complete treatment show significant symptom improvement (Stanley & Turner, 1995). In a meta-analysis of 24 outcome studies, Abramowitz (1996) reported that ERP produced large effect sizes indicating that most patients experienced substantial reductions in OCD symptoms.

If ERP has been such an effective form of treatment for OCD, why introduce a cognitive component to this treatment regimen? Is the shift from a behavioral to a cognitive focus justified, given the effectiveness of ERP? Can we expect cognitive-behavior therapy (CBT) to significantly improve on the effectiveness of established behavioral treatment approaches to OCD? A number of researchers have discussed reasons for advocating a cognitive perspective on theory, research, and treatment in OCD (Salkovskis, 1985; Whittal & McLean, 1999). First, a significant number of patients (20% to 30%) refuse to begin ERP or terminate treatment prematurely (Stanley & Turner, 1995). Second, long-term follow-up studies indicate that for many patients residual OCD symptoms remain even after an intensive course of CBT (Whittal & McLean). Third, ERP has been less effective with certain subtypes of OCD, such as those with pure ob-
sessions and no overt compulsions (Freeston & Ladouceur, 1999) or individuals with compulsive hoarding (Frost & Steketee, 1999). Fourth, a significant number of individuals (20% to 30%) appear to be treatment resistant (Sookman & Pinard, 1999), failing to show significant improvement from either CBT or pharmacotherapy. Fifth, there are a variety of psychological factors, such as low motivation, negative expectancies for treatment success, procrastination, and noncompliance, that may interfere with response to ERP. And, finally, the prominence of cognitive biases, dysfunctional beliefs, and erroneous thinking in the disorder suggests that the cognitive component of OCD should be addressed more directly in any treatment regimen.

This special series of Cognitive and Behavioral Practice is devoted to the description, application, and discussion of cognitive behavioral treatment of OCD. The five papers in the series all focus on the development and application of different variants of CBT for treatment of OCD, or specific subtypes of OCD. Each of the papers presents new, innovative, and very promising approaches to the treatment of OCD. However, given that CB treatment for OCD is still in its infancy, relatively few systematic controlled outcome studies have been conducted to verify the effectiveness of the interventions advocated in these papers. Nevertheless, most clinicians will agree that new and innovative psychological interventions for OCD are needed, and so these papers present the reader with the very latest original ideas for the cognitive treatment of obsessive and compulsive problems. In the remainder of this commentary I will like to draw out some of the similarities in theory, issues, and treatment that cut across these various papers. Despite differences in the OCD symptomatology targeted and in the particular intervention strategies emphasized, I will argue that there is a common or standard CBT theory and treatment perspective that can be discerned in these papers.

**Cognitive Theory of OCD**

One of the first impressions one obtains from reading the papers in this special series is the critical role that theory plays in cognitive-behavioral treatment of OCD. Freeston and Ladouceur (1999) present their cognitive model of obsessive thoughts, Sookman and Pinard (1999) describe a cognitive-developmental perspective of OCD, Frost and Steketee (1999) discuss a cognitive-behavioral formulation for compulsive hoarding, and Whittal and Mclean (1999) explain the theoretical tenets of their group CBT, drawing on the theoretical work of Salikowski (1985, 1996), van Oppen and Arntz (1994), and Freeston, Rhéaume, and Ladouceur (1996). This very close link between theory and therapy is integral to the practice of CBT for OCD.

Cognitive behavioral treatment for OCD is not defined in terms of a unique set of intervention strategies developed exclusively for the treatment of obsessions and compulsions. Instead, therapeutic tasks such as exposure, response prevention, construction of a fear hierarchy, self-monitoring, cognitive restructuring, and behavioral experiments are "borrowed" from established cognitive and behavioral treatment packages applied to other disorders. However, CBT does represent a unique way of conceptualizing obsessive and compulsive problems. It is the theoretical perspective or how one understands OC phenomena that is unique to CBT. What follows in CBT, then, is the implementation of this model in each therapy session. This also means that treatment manuals of CBT must at the outset devote considerable space to a fairly detailed exposition of the cognitive model of OCD so that the clinician is able to educate the client into the CB model before any specific interventions are introduced.

There are a number of implications that follow from this very tight coupling of theory and practice. First, a thorough assessment and case formulation is necessary before implementing a treatment strategy. Each of the authors in the present series emphasized the necessity of a detailed assessment, especially of the cognitive and behavioral processes that underlie OC phenomena. Cognitive theory of OCD informs the clinician of the cognitive constructs that must be identified during the assessment process, which are then used to develop a viable treatment program. Second, the cognitive model of OCD guides and directs the implementation of CBT for each patient. The initial sessions are devoted to educating the patient about the cognitive model of OCD. A number of the authors emphasized the importance of this component of the treatment package. We know from clinical experience and research on cognitive therapy for depression or panic disorder that patients must "buy into" a cognitive explanation for their symptoms if they are to benefit from cognitive intervention strategies. Thus, in CBT, cognitive theory is so important that it is directly and explicitly taught to the patient at the outset of treatment. A third implication of this tight coupling between theory and practice is that the cognitive behavioral therapist
must have a thorough understanding of cognitive theory of OCD. CBT cannot be implemented simply by following a treatment manual. Rather, the clinician using CBT for OCD must have an advanced understanding of the cognitive basis of obsessive-compulsive phenomena in order to conduct the treatment effectively.

A number of writers have presented cognitive models of OCD (Clark & Purdon, 1993; Freeston et al., 1996; Rachman, 1997, 1998; Salkovskis, 1985, 1989, 1996; van Oppen & Arntz, 1994; Wells & Matthews, 1994). Although there are some distinctive features among these different accounts, there is a remarkable degree of consensus on the essential components for a theoretical framework on which the various cognitive models of OCD are constructed. This theoretical framework is evident in the current series of papers. The following constructs, then, can be found in most cognitive models of OCD. These have been summarized in Table 1.

Table 1
Summary of the Central Constructs Shared by Cognitive Models of OCD

| 1. Normality of intrusions: assumption that normal and pathological intrusive thoughts lie on a continuum |
| 2. Faulty appraisals of intrusions: the core problem in OCD is the faulty appraisal of unwanted intrusive thoughts or obsessions |
| 3. Neutralization and avoidance: presence of overt or covert neutralizing strategies will increase the salience of the obsession, and avoidance will reinforce faulty interpretations of the intrusive thought |
| 4. Dysfunctional beliefs: the faulty appraisals of the obsession-prone individual are rooted in latent maladaptive beliefs or schemas involving themes of threat, danger, responsibility, uncertainty, importance of control, perfectionism, and the like |

The Normality of Intrusions
Most CBT models begin by recognizing that unwanted intrusive thoughts, images, and impulses occur as a normal part of human experience (i.e., Rachman & de Silva, 1978). What distinguishes normal from abnormal obsessions is a matter of degree rather than kind.

Faulty Appraisals of Intrusions
According to cognitive theories, the core problem in OCD is the faulty appraisal of unwanted intrusive thoughts, images, or impulses. A variety of pathological appraisals or interpretative processes have been implicated in the pathogenesis of obsessions. These include appraisals of inflated personal responsibility, importance of thoughts, thought-action fusion, overestimation of threat or danger, negative consequences of ineffective thought control, intolerance of uncertainty, and perfectionistic standards. Which particular appraisal process is emphasized in a model will depend on the theorist and the particular OC phenomena under consideration. For example, faulty appraisals of personal responsibility may be most salient with "loss of control" obsessions involving aggressive or inappropriate sexual behavior, whereas perfectionistic standards in the form of indecisiveness may be most prominent in hoarding (Frost & Steketee, 1999). However, what makes all of these appraisal processes pathological is that they offer evaluations that exaggerate the sense of personal significance and threat of unwanted intrusive thoughts, thereby leading to an escalation in the frequency, intensity, and salience of the intrusions (Rachman, 1997, 1998).

Neutralization and Avoidance
Cognitive models of OCD continue to recognize that neutralization, whether in the form of thought control strategies, or behavioral or mentalistic rituals, plays an important role in the onset and persistence of OCD. There is some disagreement over whether neutralization strategies function to reduce anxiety or one of the appraisal processes such as an inflated sense of responsibility. Whatever the case, there is broad agreement among CBT researchers that neutralization and other compulsive behavior increases the salience of the unwanted obsessive thought. Avoidance of situations or stimuli will also increase the salience of obsessions by reinforcing the faulty interpretations of the patient (e.g., "I feel better when avoiding public washrooms, so these must be dangerous places").

Dysfunctional Beliefs or Schemas
Each of the authors in this series recognized that underlying maladaptive beliefs may be responsible for the faulty appraisals obsession-prone individuals generate in response to their unwanted intrusive thoughts. The content of these maladaptive beliefs matches the focus evident in the appraisal processes. Thus, themes of threat, danger, perfectionism, uncertainty, responsibility, and loss of control characterize the dysfunctional beliefs of the obsessive-compulsive individual. However, it must be recognized that the content of the dysfunctional beliefs associated with different subtypes of OCD may be unique to that particular subtype, such as the collecting and discarding beliefs of hoarders (Frost & Steketee, 1999). Currently an international group of OCD researchers is working on the development of measures to assess dysfunctional beliefs and appraisals in OCD (Obsessive-Compulsive Cognitions Working Group, 1997).

Cognitive Behavior Therapy for OCD
Despite nuances in the various CBT treatment approaches described by the authors in this series, we do
see a number of common elements in their treatment packages. Of course these elements take a different orientation or focus depending on the obsessive-compulsive phenomena under consideration. Having said this, the following are some common therapeutic ingredients that are found in most cognitive-behavioral interventions for OCD. A summary of these seven common therapeutic components can be found in Table 2.

Educating the Client to the Cognitive Model
As noted previously, each of the authors emphasizes the importance of educating the patient to the cognitive model of OCD. It is critical that this educational aspect of CBT not degenerate into an intellectual exercise; rather, the model should be illustrated using the patient’s own obsessions, appraisals, beliefs, and neutralizing strategies (Freeston & Ladouceur, 1999). If patients “buy into” the cognitive explanation for their obsessions and compulsions, then they are more likely to be motivated for treatment, collaborate in the identification of dysfunctional thinking, and complete homework assignments. On the other hand, it will be very difficult for patients to adopt a collaborative stance on interventions that focus on the identification and modification of cognitions if they remain skeptical over the relevance of the cognitive model for their condition.

In addition, Freeston and Ladouceur (1999) noted that another reason for presenting the cognitive model is to normalize patients’ experience of obsessions by showing them the connection between pathological obsessions and the unwanted intrusions that occur in the normal population. However, one should not underestimate how difficult it may be to convince someone that the onset and persistence of their obsessions is affected by their faulty interpretations. Many patients come into therapy with strongly held beliefs that their OCD is a disease stemming from a “chemical imbalance” or “genetic deficit.” For these patients, the educational phase of CBT may take considerably longer than one to two sessions described in the treatment manuals.

Educating the client into the cognitive model of OCD will also include an introduction to the concept of “faulty appraisals” of the obsession. At this initial stage of therapy, the client is simply introduced to the idea of appraisals or “giving importance to the obsession” as the primary reason for the thought’s persistence. In educating the client, the clinician will also refer to the different types of appraisals that underlie obsessional phenomena, and will suggest to the client the possibility that these appraisals are faulty or incorrect. However, no attempt is made to persuade clients that their appraisals are faulty. Rather, in the second phase of treatment, the clinician uses collaboration and guided discovery in order for clients to test out the realistic or faulty basis of their appraisals.

Identifying Faulty Interpretations, Neutralizing Strategies, and Avoidance Patterns
All of the authors emphasize that patients must be trained to recognize the faulty appraisals and futile neutralizing behavior and thought-control strategies they engage in once an obsessional thought intrudes into consciousness. Freeston and Ladouceur (1999) use daily self-monitoring and other exercises to help clients learn the external and internal factors, such as anxiety, avoidance, magical thinking, and reassurance seeking, that strengthen a faulty appraisal process. Whittal and McLean (1999) note that it is important that patients be trained to distinguish between the intrusive thought and the appraisals or interpretations they generate about the intrusion. This distinction will be difficult for some patients who have become utterly preoccupied with the obsessional thought. Frost and Steketee (1999) commented that hoarders may find it particularly difficult to identify the triggering intrusive thought and its interpretation. In addition, all of the authors noted that the identification of covert or overt neutralizing rituals, avoidance patterns, and other maladaptive coping strategies is a critical component of CBT for obsessions and compulsions. Behavioral change is still an important part of CBT, despite the increased emphasis on cognitive factors.
Cognitive Restructuring of Faulty Appraisals

Freeston and Ladouceur (1999), Whittal and McLean (1999), and Frost and Steketee (1999) all discuss various approaches that can be used to cognitively challenge the faulty appraisals and maladaptive beliefs that constitute the cognitive basis to the patient’s obsessions and compulsions. All emphasize that the use of logical persuasion or “cognitive challenge” must be done in a collaborative manner with the use of Socratic dialogue and guided discovery. Whittal and McLean provide patients with a list of questions that they can use to cognitively challenge the validity of their interpretations when intrusive thoughts occur. My own clinical experience in conducting CBT with obsessional patients is that they can be very rigid, narrow, and inflexible when trying to explore alternative perspectives and arguments to their interpretations and beliefs. For this reason, cognitive correction of faulty interpretations and beliefs may play a secondary role to the use of behavioral experiments or what Beck and colleagues refer to as “empirical hypothesis-testing” (Beck, Rush, Shaw, & Emery, 1979). This is not to imply that “cognitive” procedures are less useful in treating obsessions and compulsions than exposure tasks. Instead, exposure-based strategies may be necessary to challenge core dysfunctional beliefs about the importance of the obsessional thought. How the clinician explains the outcome of the exposure exercise to the client will determine whether it facilitates change in dysfunctional OCD beliefs (e.g., “Notice that when you did not check, nothing terrible happened to you, and your distress eventually abated”). In this way, both “cognitive” and “behavioral” interventions are necessary to modify core dysfunctional belief structures in OCD.

Behavioral “Experiments”

Despite the limitations of ERP noted previously, there can be little doubt that exposure and response prevention are vital to CBT of OCD. The amount of therapy time devoted to ERP will vary depending on the particular OCD subtype, with, for example, ERP playing a very prominent role in the treatment of compulsive washers. However, the function of ERP in CBT is different than the function it plays in behavior therapy. In CBT, exposure and response prevention exercises are considered critical for testing out faulty appraisals and maladaptive beliefs. This is not to deny that habituation to anxiogenic obsessions may also occur. However, in CBT, exposure is used to challenge existing ideas about the importance and consequence of obsessions and compulsions.

To illustrate this point, a few years ago I treated a man who had very upsetting intrusive thoughts of losing control and murdering his wife with a hammer. He believed that the more he had this thought, the more likely it would be that he would lose control and commit murder (i.e., appraisals of overestimated threat, inflated responsibility, thought-action fusion, and importance of thoughts). For a homework assignment he was to spend 30 minutes each day focused on the murderous thought and to avoid any attempt to suppress the thought. After 1 week he reported a dramatic reduction in the frequency and level of distress associated with the murderous thought; he did not feel an increase in murderous impulses.
therapist must work with patients on the development of alternative, healthier modes of thinking. Whittal and McLean (1999) did note that they spend time in the latter part of their treatment program on the development of alternative appraisals and beliefs. It is not enough for therapy to challenge the faulty appraisals and maladaptive beliefs of the obsessional patient. Treatment effects will last only to the extent that obsession-prone individuals develop stronger beliefs in more functional interpretations of their intrusive thoughts. For example, if a patient begins to doubt that “thinking about stabbing a friend means that I could stab him,” then that individual must adopt a different interpretation of the intrusive thought. If the thought is not an indication of latent homicidal tendencies, then where do these thoughts come from? What do they mean? Why do we have them? A credible alternative explanation for these intrusions must be available to patients if they are to abandon their maladaptive thinking patterns.

Correcting Dysfunctional Beliefs

A number of authors note that CBT does not focus only on the appraisals of obsessions but, later in treatment, one must shift the therapeutic agenda to the identification and correction of the maladaptive beliefs that lead to faulty appraisals. Work is currently in progress to isolate the core, critical beliefs of OCD and to develop valid and reliable measures of these beliefs (Obsessive-Compulsive Cognitions Working Group, 1997). We assume that treatment gains from CBT will be maintained only if the core underlying maladaptive beliefs are modified. Thus the correction of dysfunctional OCD beliefs and assumptions may be necessary to reduce relapse and reoccurrence of OC symptoms.

Relapse Prevention

Relapse prevention must be worked into CBT programs if treatment gains are to be maintained. Neziroglu, Stevens, Yaryura-Tobias, and Hoffman (1999) identified a number of factors that may be associated with poor response to treatment. Whittal and McLean (1999) provide patients with a list of strategies they can use to deal with intrusive thoughts after therapy has ceased. Given the chronic nature of OCD, relapse prevention must be built into each CBT regimen.

Pitfalls in Cognitive-Behavioral Treatment of OCD

Several of the authors in this series raise a number of interesting problems that can arise when employing cognitive-behavioral approaches to OCD (Freeston & Ladouceur, 1999; Frost & Steketee, 1999; Neziroglu et al., 1999; Whittal & McLean, 1999; see also comments by van Oppen & Arntz, 1994). I would like to briefly highlight three of the complications. First, the therapist must identify occasions when patients turn therapeutic interventions into neutralizing strategies. As an example, I treated a young man who suffered with obsessional ruminations involving unwanted sex and violence. He experienced a significant reduction in the frequency and intensity of his obsessions after being taught to cognitively challenge the faulty appraisal that “these violent thoughts mean that I am a dangerous person who might become violent.” However, a few years later he again contacted me, reporting that the violent thoughts had returned. Interestingly, he was compulsively monitoring these thoughts and challenging them each time they occurred. The problem is that the cognitive restructuring was now being used as a thought-control strategy, and as such increased the salience of the violence thoughts. So the first point of intervention was to discontinue the use of cognitive restructuring. Freeston and Ladouceur (1999) offer some very practical advice on how therapists can distinguish between responses that are in aid of neutralizing and those that constitute a healthy evaluation of the intrusion.

A second complication in conducting CBT for obsessional problems is the possibility that patients will use the therapeutic support, advice, and other cognitive interventions as reassurance against the threat or danger they perceive from the obsession. Freeston and Ladouceur (1999) note that reassurance seeking is a form of neutralization that can increase the perceived importance of the intrusive thought. When patients directly solicit reassurance from the therapist or significant others, Freeston and Ladouceur suggest that individuals respond to the patient in a calm, nonaggressive manner, emphasizing that they will not provide the reassurance the patient seeks. Whittal and McLean (1999) comment that patients can turn a healthy, alternative appraisal into a form of reassurance. Thus, CB therapists must be vigilant that their therapeutic interventions are not converted by patients into some form of neutralizing ritual, thought-control strategy, or reassurance.

Finally, a number of authors discuss the problem of low motivation and noncompliance with homework assignments, which will undermine the treatment integrity of CBT (see Frost & Steketee, 1999; Neziroglu et al., 1999). These problems are not unique to OCD or CBT. Low motivation and noncompliance will reduce the effectiveness of any psychological intervention. However, it
may be that these problems are especially prominent in obsessive and compulsive disorders. OCD is a very chronic condition and so individuals will often restructure their lives around their symptomatology. Thus, the reduction or elimination of obsessive-compulsive symptoms might be perceived as an attack on an integral part of one’s personal identity. If one adds to this the very high level of fear and anxiety associated with obsessions and the situations that trigger them, then it is understandable why some patients with OCD find it difficult to commit themselves to therapy. At the very least, the CB therapist must deal directly with low motivation and noncompliance of homework assignments by identifying and challenging the thoughts and beliefs that might underlie ambivalence for treatment.

Conclusion

The papers in this series describe the application of cognitive-behavioral intervention for the treatment of obsessive and compulsive symptoms. Despite the treatment innovation and promise represented in these papers, it must be realized that the effectiveness and clinical utility of CB treatment for OCD is not yet proven. We do have some case reports that this treatment approach can be effective (Frost & Steketee, 1999; Ladouceur, Freeston, Gagnon, Thibodeau & Dumont, 1995; Kearney & Silverman, 1990; Salkovskis & Warwick, 1985; Sookman & Pinard, 1999). As well, a few clinical outcome studies have been published which again support the clinical effectiveness of CBT for obsessive and compulsive symptoms (Emmelkamp & Beens, 1991; Emmelkamp, Visser, & Hoekstra, 1988; Freeston et al., 1997). There are also a number of clinical outcome trials of CBT in progress (see Frost & Steketee, 1999; Whittal & McLean, 1999), so we should be in a much better position within the next couple of years to judge the effectiveness of CBT for obsessive-compulsive disorders.

In the introduction I argued that the cognitive innovations reported in these papers represent an important development for the treatment of OCD. However, at this point we do not have any systematic empirical evidence that the cognitive component of CBT adds significantly to the effectiveness of psychological treatment for OCD beyond the established effects of ERP. In addition, we do not know whether CBT significantly reduces the treatment refusal and dropout rates seen with ERP, nor is there any evidence that CBT produces more complete remission of obsessive-compulsive symptoms or reduces relapse and recurrence rates. It is also not known whether CBT is effective with obsessional patients who are drug-refractory or treatment resistant, although the results of Sookman and Pinard (1999) are encouraging. Nor is it known whether CBT can readdress factors that undermine treatment effectiveness like low motivation and noncompliance with ERP. Clearly, there is a great deal of empirical research, theoretical elaboration, and clinical refinement that is needed before CBT becomes an established form of treatment for OCD. Until then, the current work suggests that CBT offers a refreshing and highly promising new perspective on the treatment of OCD.

References

Series Response: Compliance and Understanding OCD

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This response to the series focuses on the differentiation between research and clinical work, reminding the reader that research protocols are not treatment protocols and treatment protocols are guidelines, not cookbooks. Too often we stray from the ideal of the scientist/practitioner model, in which practitioners are influenced by research and researchers by clinicians. Within this context three broad areas will be addressed: (1) the role of treating the whole person versus their OCD only; (2) the use of group treatments; and (3) the art of how we explain OCD to ourselves and to those suffering from it.

Learning how to do behavior therapy is fairly simple; obtaining patient compliance is an art. Cognitive behavior therapy’s excessive focus on technology is the result of its greatest strength: reliance upon empiricism. However, as researchers, there are times we forget that the treatment offered in a controlled study is often not treatment; that a research protocol designed for the purpose of constraint and control is not a treatment protocol. For psychology to advance as a science and a service, the abuse of constraint and control is not a phenomenon we should tolerate.

For decades researchers have ambitiously created therapy programs that go beyond one-dimensional behavioral treatment of obsessive-compulsive disorder (OCD) and obsessive-compulsive spectrum disorders. Clark’s (1999) summary of the series provides an excellent integration and synthesis of everyone’s work—which leaves me free to focus on art and compliance.

With regard to compliance, three issues will be discussed, two raised by the series and one which I found to be inadequately covered by the series: (1) the role of treating the whole person versus their OCD only; (2) the use of group treatments; and (3) the art of how we explain OCD to ourselves and to those suffering from it. Although most of this paper’s attention will be spent upon the last, all represent different pieces of what constitutes the best treatment for the individual suffering from OCD.

Treatment refusal and dropouts were among the compliance issues raised by a few of the series’ authors. The dropout rate at our center is not as large as reported elsewhere (Stanley & Turner, 1995)—presumably for the reasons discussed below. On the other hand, we don’t know how many OCD sufferers choose not to come to our center because they know a major component of their treatment will be exposure and response prevention (ERP). Although ERP is a central component of our OCD treatment program, we do treat the whole person. For some of our clients, OCD is the only presenting problem, while for others, OCD may simply be the most obviously dis-