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Knowledge and competency standards for specialized cognitive behavior therapy for adult obsessive-compulsive disorder: phase two series by the International Accreditation Task Force of The Canadian Institute for Obsessive Compulsive Disorders (CIOCD, www.ciocd.ca)

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Sookman, D., Phillips, K. A., Anholt, G. E., Bhar, S., Bream, V., Challacombe, F. L., Coughtrey, A., Craske, M. G., Foa, E., Gagne, J.-P., Huppert, J. D., Jacobi, D., Lovell, K., McLean, C. P., Neziroglu, F., Pedley, R., Perrin, S., Pinto, A., Pollard, C. A., Radomsky, A., Riemann, B., Shafran, R., Simos, G., Sochting, I., Summerfeldt, L. J., Szymanski, J., Treanor, M., van Noppen, B., van Oppen, P., Whittal, M., Williams, M. T., Williams, T. ORCID: https://orcid.org/0000-0003-0072-3316, Yadin, E. and Veale, D. (2021) Knowledge and competency standards for specialized cognitive behavior therapy for adult obsessive-compulsive disorder: phase two series by the International Accreditation Task Force of The Canadian Institute for Obsessive Compulsive Disorders (CIOCD, www.ciocd.ca). Psychiatry Research, 303. 113752. ISSN 0165-1781 doi: 10.1016/j.psychres.2021.113752 Available at

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To link to this article DOI: http://dx.doi.org/10.1016/j.psychres.2021.113752

Publisher: Elsevier

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Knowledge and competency standards for specialized cognitive behavior therapy for adult obsessive-compulsive disorder: phase two series by the International Accreditation Task Force of The Canadian Institute for Obsessive Compulsive Disorders (CIOCD, www.ciocd.ca)

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Abstract

Obsessive-Compulsive Disorder (OCD) is a leading cause of disability world-wide (World Health Organization, 2008). Treatment of OCD is a specialized field whose aim is recovery from illness for as many patients as possible. The evidence-based psychotherapeutic treatment for OCD is specialized cognitive behavior therapy (CBT, NICE, 2005, Koran and Simpson, 2013). However, these treatments are not accessible to many sufferers around the world. Currently available guidelines for care are deemed to be essential but insufficient because of highly variable clinician knowledge and competencies specific to OCD. The phase two mandate of the 14 nation International OCD Accreditation Task Force (ATF) created by the Canadian Institute for Obsessive Compulsive Disorders is development of knowledge and competency standards for specialized treatments for OCD through the lifespan deemed by experts to be foundational to transformative change in this field. This paper presents knowledge and competency standards for specialized CBT for adult OCD developed to inform, advance, and offer a model for clinical practice and training for OCD. During upcoming ATF phases three and four criteria and processes for training in specialized treatments for OCD through the lifespan for certification (individuals) and accreditation (sites) will be developed based on the ATF standards.

Key Words: exposure and response prevention, cognitive therapy, evidence based treatment, training, certification, accreditation

1 Introduction

Obsessive Compulsive Disorder (OCD) is a leading cause of disability world-wide (World Health Organization, 2008). Affecting approximately 3% of the population through the lifespan, OCD is recognized as a major mental illness from which sufferers experience impaired functioning across domains on par with major physical illnesses and schizophrenia (Koran et al. 1996; Bystritsky et al. 2001). Prevalence is reportedly higher with consideration of "prodromal syndromes" that are at high risk of development of serious illness (Fullana et al. 2009; Thompson et al, 2020). This disorder is commonly associated with high levels of distress, depression, and hopelessness, as well as serious psychosocial dysfunction and reduced quality of life secondary to symptoms (Hollander et al. 2010). Multi-sphere impairment often occurs in basic self-care and parenting, intra-familial and social functioning, and capacity for school or work. Without early accurate diagnosis and specialized intervention OCD often rapidly worsens and may result in longstanding or irreversible developmental impairment. Duration and severity of illness impact outcome, highlighting the importance of early intervention (Eisen et al. 2013; Fineberg et al. 2019). Severity and chronicity of illness are associated with high healthcare costs and hospitalizations. Approximately 25% of severely ill patients attempt suicide (Kamath et al. 2007).

Treatment of OCD is currently a specialized field whose aim is recovery of symptoms and restoration of psychosocial functioning for as many patients as possible. The first line evidence-based psychotherapeutic treatment of choice for OCD is specialized cognitive behavior therapy (CBT), including exposure and response prevention (ERP, NICE, 2006; Koran, 2007; Koran and Simpson, 2013). Most experts recommend that cognitive therapy (CT) and behavioral experiments be combined in evidence-based approaches for adult OCD (e.g., Berman et al. 2019; Falkenstein et al. 2020). Several studies have demonstrated the efficacy of both ERP and CT in reducing symptoms and related dysfunctional beliefs (Olatunji et al. 2013). Dropout rates have been reported to be lower with cognitive interventions (Foa et al. 2005; Wilhelm et al. 2009). Individuals with OCD report varied emotional responses and complex metacognitive dysfunction that may be difficult to ameliorate with ERP alone (Sookman, 2016). Importantly, patients with different OCD subtypes respond differentially to specific CBT interventions (e.g., Rachman et al. 2015; Radomsky et al. 2020a, 2020b), with approximately 81% of respondents endorsing multiple symptoms (Ruscio et al. 2010). There have been numerous studies on optimal procedural variants of CBT for OCD

subtypes; however, there remains a lag between development of these approaches and methodologically adequate controlled outcome studies to examine their efficacy. Family/significant other involvement to reduce accommodation of symptoms and adherence to homework are important predictors of positive outcome (Simpson et al. 2012; Lebowitz et al. 2016). Internet based CBT for OCD has shown promise for dissemination to remote regions and requires further examination (e.g., Lenhard, et al. 2020; Wheaton et al. 2020). Research is ongoing to develop and examine innovative approaches, for example, specialty CBT for mental contamination (e.g., Rachman, 2015) and imagery re-scripting for patients reporting distressing imagery related to aversive memories (e.g., Veale et al. 2015; Maloney et al. 2019) or excessive feelings of guilt (Tenore et al. 2020).

Curative evidence-based specialized treatments are available at international specialized centers for OCD. However, these treatments are not currently accessible to many sufferers because of an insufficient number of clinicians and sites with the requisite knowledge, competencies, and experience. This mental health crisis characterized by lengthy delays in diagnosis and unavailability of evidence-based specialty treatment spans multiple international regions, resulting in progression to disabling illness for many persons (Dell Osso et al. 2010; Szymanski, 2012; Drummond et al. 2013; Veale, 2018; Brakoulis et al. 2019). Early detection and evidence-based treatment improve recovery rates; however, evidence-based early intervention is not commonly available (Hollander et al. 2010, Fineberg et al. 2019). Without effective treatment, remission rates among adults with OCD are low (approximately 20%, Skoog and Skoog, 1999). "Stepped care" has to date not been sufficiently empirically validated for OCD and runs the serious risk of undertreating the disorder (Sookman and Fineberg, 2015; Lovell et al. 2017; Veale, 2018). Failure to receive CBT reliably predicts poor outcome; however, many individuals with OCD do not receive CBT, and fewer still receive specialized CBT for OCD delivered or supervised by a therapist experienced with this disorder (Stobie et al. 2007; Lovell and Bee, 2008; Shafran et al. 2009; Hipol and Deacon, 2013; Harned et al. 2014; Fernandez de la Cruzet al. 2015; Reese at al, 2016; Smith et al. 2017). Furthermore, medication prescription practices may often not be consistent with evidence-based guidelines or optimized for OCD (Van Ameringen et al. 2014; Isomura et al. 2016). These results highlight the urgent need for dissemination of expertise in evidence-based treatments for OCD.

The International Obsessive-Compulsive Disorders Accreditation Task Force (ATF) was created by The Canadian Institute for Obsessive Compulsive Disorders (CIOCD, www.ciocd.ca) to address the urgent need to develop measurable knowledge and competency standards recommended for specialized treatments for OCD through the lifespan, deemed by experts to be foundational to transformative change in this field. Currently available guidelines for care are essential but insufficient because of highly variable clinician knowledge and competencies specific to this disorder. The specialty standards developed by the ATF during phase two comprise evidence-based knowledge and competencies *operationalized as abilities* that are specific (and teachable/trainable), unlike existing guidelines (NICE, 2005; APA et al. 2007; Koran and Simpson, 2013). A rigorous methodological protocol has been outlined by the task force to ensure development of evidence-based standards that are integrated with expert opinion. The ATF currently comprises experts in OCD and related disorders through the lifespan representing 14 nations (Chair, Debbie Sookman, PhD Canada and Co-Chair, David Veale, MD, UK). Please see the Introductory paper of this series for further information about ATF development and mandates.

The ATF phase two series, of which this paper is a part, elaborates knowledge and competency standards for specialty cognitive behavior therapy and pharmacotherapy for pediatric and adult OCD developed by this task force. The ATF aim is to achieve transformative improvement globally in quality and accessibility of evidence-based treatments for this crippling disorder. Upcoming phases three and four will involve development and implementation of training protocols at the level of certification (individual clinicians) and accreditation (clinical sites) based on the ATF standards.

2 Method

This paper presents knowledge (K) and competency (C) standards recommended for specialized cognitive behavior therapy (CBT) for adult OCD. The overall knowledge standards presented in the Pittenger et al. paper in this series on pharmacotherapy for adult OCD that are applicable to all clinical work with these patients (e.g., clinical and diagnostic characteristics, phenomenology) are not duplicated in this paper whose focus is specialty CBT. The first author and the ATF assembled an international group of specialist clinicians with expertise in assessment and specialty CBT for adults with OCD. This group generated a list of areas of knowledge and competence, with reference to published guidelines (NICE, 2005; Koran, 2007;

Koran and Simpson, 2013), relevant literature, and their own clinical expertise. This list was refined through several iterations; topics were then distributed to group members for further elaboration.

Each section was developed by one or more members of the ATF Adult CBT group based on their specific clinical and research expertise. Categories of K and C were organized into sections presented in tabular format. Each K and C was worded *as an observable ability* with specification of the research sources selected for verification, citation of evidence using the ATF evidence legend developed for standardization across papers (Table 1), and associated references. At least two ATF authors/experts verified that a specific K or C (or class of K or C) would be considered for ATF standards based on the evidence selected. Each section includes introductory text with brief overview, definition of key terms, statement on evidence, and suggestions for future research.

Part I of the paper presents the sections on assessment, case conceptualization, psychoeducation, exposure and response prevention, cognitive therapy, homework, and family interventions. Part II presents the sections on symptom subtypes, overvalued ideation, treatment interfering behaviors, cultural adaptations, relapse prevention, and comment on co-morbidity. Individualized case conceptualization and strategies to strengthen the therapeutic relationship that are integral throughout treatment are addressed in several sections. The final standards were determined by a larger group of ATF co-authors with expertise in the specific competencies. In the interest of clarity and completeness there is some inevitable redundancy within each section's knowledge and competencies as well as between sections. These standards are deemed to be comprehensive but, necessarily, not all inclusive.

Following review of the paper sections and content editing of select sections by the first author, and iterative revision by co-authors; the paper draft was completed by the first author and circulated for commentary and edits by co-authors. The first author incorporated co-author input, and the paper was circulated to the CBT group for a second round of input. The paper was then submitted to the ATF leadership for final review and edits.

Table 1. ATF EVIDENCE LEGEND

TG: Treatment Guideline	*OCT*: Open-Label Clinical Trial	*CQS*: Clinical Qualitative Study
MA: Meta-Analysis	*CC*: Case-Control Study	*ThP*: Theoretical Paper
SR: Systematic Review	CSS: Cross-Sectional Study	*TM*: Treatment Manual or Book
OR: Other Review	*PS:* Psychometric Study	*TrPN*: Non-Data Based Treatment Paper
RCT: Randomized Controlled Trial	*CR*: Case Report or Series	*EO*: Expert Opinion
RCS: Randomized Clinical Study	*CES:* Clinical Experimental Study	*AR*: Animal Research Study
CS: Cohort Study	*AES*: Analogue Experimental Study	

3 Results

Knowledge and Competency Standards for Specialized CBT for Adult OCD: Part I

3.1 Section Name: OCD assessment

Overview

Conducting a comprehensive assessment process is essential for treatment planning and implementation of specialized CBT for OCD. Assessment is a continuous and collaborative process that both drives the progression of treatment, and, in turn, evolves through information gained by self-monitoring and patients' response to therapeutic interventions. The focus of the current section is on the assessment process preceding the beginning of treatment. A detailed clinical history is a foundational competency for diagnosis and treatment planning (APA et al, 2007; Phillips and Stein, 2014; APA, 2016). This includes developmental, familial, psychosocial, medical, psychiatric, as well as treatment history, both psychotherapeutic and pharmacological. Developmental experiences that may be important as etiological and/or maintaining factors of illness should be assessed including early stressful experiences (e.g., Vidal-Ribas et al. 2020). Assessment must be carried out in a culturally sensitive manner with attention to the creation of an accepting interpersonal environment that fosters disclosure of distressing content as much as possible. Normalization of the patient's symptoms as characteristic of OCD with communication of common examples of the inner experience of others can be helpful in reducing commonly reported feelings such as fear and shame at self-disclosure. Risk assessment is a crucial component of the initial interview (e.g., suicidality, self-harm, care of self and children). Knowledge and competency in assessment includes communication to the patient about the results of the assessment in a clear and ethical manner as well as use of assessment information in case conceptualization and specialized treatment planning. Patients' outcome expectancies and treatment goals are discussed during assessment as well as during psycho-education (Constantino et al. 2018; Priebe et al. 2020; Strauss et al. 2018). Multidisciplinary collaboration as needed during assessment and treatment planning/implementation when combined treatments (pharmacotherapy and CBT) are considered is a fundamental competency.

Description of Key Terms

Comorbidity: OCD is a disorder with high comorbidity (Brakoulias et al. 2017), and various comorbidities may require modification of the treatment plan and goals. For example, some patients with severe comorbid depression may lack the resources to collaborate with the treatment regimen and may require pharmacotherapy as well as augmentation of psychological treatment (Abramowitz, 2004). Treatment of OCD symptoms with autism may also require adaptations such as extended psychoeducation, regular home-based sessions, highly graded exposures, and increased involvement of social systems (Krebs et al. 2016; Flygare et al. 2020). Available measures for structured diagnostic interview include the Mini-International Neuropsychiatric Interview (M.I.N.I., Sheehan et al. 1998), the Structured Clinical Interview for DSM-5 disorders, (SCID-5, First et al. 2015), or the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND, Tolin et al. 2018).

Insight: The degree to which patients recognize the irrational and illogical nature of their obsessions and compulsions (Kozak and Foa, 1994). Insight is a dimensional construct that may change over time and across symptoms, however, in general poor insight is an important predictor of poor treatment outcome (Catapano et al. 2010; Shavitt, 2014; Visser et al. 2017). Importantly, insight is a dimensional construct, and it is important to assess changes across time and possible differences across various symptoms and dimensions (Shavitt et al. 2014). The most commonly used measure for insight in OCD is the Brown Assessment of Beliefs Scale (BABS; Eisen et al. 1998). The section on overvalued ideation in this paper addresses this dimension further.

Measurement of symptom severity and symptom subtypes: The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS, Goodman et al. 1989ab) is a semi-structured interview which constitutes the gold standard of OCD severity measurement. It is unique in that it measures overall severity directly, unrelated to the number and subtype of symptoms patients have. OCD patients usually score 16 and above on the Y-BOCS (scores range from 0 to 40). The Y-BOCS is also the most sensitive measure of treatment change (Anholt et al. 2010). A revised, updated version of the Y-BOCS is available (YBOCS II, Storch et al. 2010), although most studies thus far have been conducted using the original version. Although the Y-BOCS entails a checklist of symptoms, it does not measure severity of specific symptom subtypes. Therefore, it may be beneficial to separately administer a questionnaire measuring severity of various symptoms (e.g., the Padua Inventory-Revised, Van Oppen et al. 1995) or the Obsessive-Compulsive Inventory-Revised, (Foa et al. 2002). Congruency of Y-BOCS self- and clinician-rating over time is variable, and inferior for obsessions relative to compulsions (Hauschildt, et al. 2019). Other interview-based assessment (e.g., International Intrusive Thoughts Interview Schedule-IITIS) was found to discriminate degree of intrusive thoughts while the self-report Y-BOCS and the Y-BOCS-Symptom Checklist did not (Simos and Ntouros, 2012) suggesting need for revision of Y-BOCS. In addition to these general OCD symptom scales measures have been developed to assess specific phenomena and symptom presentations, such as relationship OCD symptoms (the relationship OCD inventory, ROCI, Doron et al. 2012), scrupulosity (the Penn inventory of scrupulosity, PIOS, Abramowitz et al. 2002), not just right phenomena (the Vancouver obsessional compulsive inventory – just right scale, VOCI-JR; Thordarson et al. 2004), and several mental contamination measures (the Vancouver obsessional

compulsive inventory—mental contamination scale, the contamination sensitivity scale, and the contamination thought-action fusion scale, Radomsky et al. 2014).

Functional analysis: Central to psychoeducation and treatment planning in specialized cognitive-behavior therapy (CBT) is the functional analysis (Kim et al. 2016). This refers to the identification of the maintaining cycle of internal or external triggers, related obsessions (verbal, images, urges, and sensory phenomena), cognitions (appraisals, beliefs, core fears, catastrophic scenarios), compulsions, avoidance, and related feelings (e.g., distress, fear, guilt, shame). Relevant questions in understanding the patient's inner experience may include, for example: "When you had the obsession 'I may have forgotten the gas stove,' what was the meaning of this thought? What were you afraid would happen if you did not check?". Core fears can be ascertained through a series of downward-arrow questions. The downward-arrow should be followed systematically until the most catastrophic scenarios are exhausted (Huppert and Zlotnick, 2012). This information can be utilized later in behavioral experiments, in vivo or imaginal exposures, or in other interventions such as imagery rescripting. Finally, all compulsions (overt and covert), safety-behaviors (e.g., reassurance seeking) and avoidance should be assessed.

The two gold standard measures of OCD-related cognitions are: (1) the Interpretation of Intrusions Inventory (III) and (2) the Obsessive-Beliefs Questionnaire (OBQ) developed by the Obsessive-Compulsive Cognitions Working Group (OCCWG, 2001, 2005). The III measures current appraisal of intrusive thoughts related to responsibility, control, and importance of thoughts. The OBQ measures more general beliefs that are specific to or characteristic of OCD. The original OBQ-87 consisted of the following belief domains: inflated responsibility, overestimation of threat, intolerance of uncertainty, perfectionism, and importance and control of thoughts. These domains were later reduced to three through factor analytic procedures in the OBQ-44 (OCCWG, 2005). Use of the OBQ-87 has advantages clinically because of its separate subscales for overestimation of threat and inflated responsibility, important in assessing patients who do not report beliefs related to excessive responsibility. However, not all patients report an elevation in these cognitions (Taylor et al. 2006), and changes in the OBQ do not necessarily precede symptom change (Lorenzo-Luaces et al. 2016). OBQ is also available in shorter forms (Fergus et al. 2019; Moulding et al. 2011).

Psychosocial functioning and quality of life: Psychosocial functioning and quality of life of OCD patients are often greatly affected by symptoms (Huppert et al. 2009). Two relevant measures include the 36-Item Short Form Health Survey questionnaire (Wade, 1993) and the Work and Social Adjustment Scale (Mundt et al. 2002). It is useful to assess the direct influence that symptoms have on functioning in specific domains (e.g., impaired academic achievement) as well as the long term-consequences of symptoms. OCD is often extremely time consuming and disabling, and particularly subsequent to early onset or chronicity of symptoms important life functioning needs to be restored (Anholt et al. 2014). Treatment gains are more likely to be maintained if beyond symptom reduction there is also an increase in level of psychosocial functioning and quality of life. Special attention should be placed on self-care and care of children as, in some cases, symptoms may be endangering (e.g., not letting a baby crawl due to contamination obsessions). It is important to assess the influence of symptoms on parenthood, for example, maternal postpartum OCD can affect experiences of parenting and mother-infant interactions (Challacombe et al. 2016), and the risk for the development of OCD in children.

Values and goals: The assessment of values and goals is important in several ways (see also Huppert and Zlotnick, 2012). First, obsessions typically arise in response to intrusions of personally important values (Rachman, 2003). Compulsions often aim at preventing harm to these goals or values but exert a paradoxical effect. Addition of adjunctive interventions may improve treatment engagement for some

cases (e.g., acceptance and commitment therapy, Twohig et al. 2006).

Familial accommodation: The degree to which family members participate in compulsions or change their routine as a consequence of symptoms negatively impacts treatment outcome (Amir et al. 2000). Importantly, the opposite is also true -- being critical of symptoms also negatively impacts insight and is associated with higher symptom severity (De Berardis et al. 2008). This important area in elaborated elsewhere in this paper.

Level of Evidence

The Y-BOCS and symptom self-report measures, as well as measures assessing related constructs (e.g., relationship OCD; Doron et al. 2012), have good to excellent psychometric properties including high internal reliability, test-retest reliability, and convergent and divergent validity. Whereas many of the global self-report measures have been validated in clinical samples (e.g., OCI-R, BOCI, VOCI), validation of the related constructs has been slower (e.g., scrupulosity- Huppert and Fradkin, 2016). On initial assessment and when assessing treatment progress it is important to consider discrepancies between the Y-BOCS clinician interview, patients' self-report, and observed behavior.

Recommendations for Further Research

Further studies are needed to examine updated OCD measures (e.g., Fatori, et al. 2020) as well as the specificity of standardized measures used to assess OCD (Huppert et al. 2007; Huppert and Fradkin, 2016). Ongoing research on assessment and specialty treatments for the symptom subtypes discussed elsewhere in this paper is strongly indicated. Assessment of developmental experiences that may be relevant to intransigence of OCD symptoms merit further study (e.g., Sookman et al. 2001; Berman et al. 2019). Further research is indicated on case conceptualization in specialized CBT for OCD that integrates assessment with the case relevant evidence base in relation to outcome (Salkovskis and Forrester, 2002; Zivor et al. 2013; Nattrass et al. 2015).

OCD ASSESSMENT **Specialty Knowledge:**
Ability to demonstrate knowledge of the elements and process to take a complete history, including developmental, familial, psychosocial, medical, psychiatric, and treatment history
Evidence: *TG,* Koran et al. (2007); American Psychiatric Association (2016). *MA,* Constantino et al. (2018). *OR,* Priebe et al. (2020). *RCS,* Strauss et al. (2018). *TM,* Phillips and Stein, (2014).

Ability to demonstrate knowledge of DSM 5/ ICD -11 criteria including knowledge of OCD diagnosis and importance of age of onset, differential diagnosis and co-morbidities (e.g., anxiety, mood, substance use/abuse, tics/Tourette's syndrome, body dysmorphic disorder, hoarding, psychotic disorders)
Evidence: *OR*, Abramowitz (2004). *CSS*, Brakoulias et al. (2017). *PS*, Sheehan et al. (1998). *CR*, Krebs et al. (2016). *CES*, Lobbestael et al. (2011).

Ability to demonstrate knowledge of various measures of symptom severity and symptom subtypes/ specific symptom presentations
Evidence: *CSS*, Anholt et al. (2010); Simos and Ntouros, (2012). *PS*, Anholt et al. (2009); Coles et al. (2003); Doron et al. (2012); Fergus et al. (2019); Foa et al. (2002); Goodman et al. (1989ab); Hauschildt, et al. (2019). Moulding et al. (2011), OCCWG (2005); Storch et al. (2010); Van Oppen et al. (1995). *TM*, Foa et al. (2012).

Ability to demonstrate knowledge of risk assessment. including secondary risk (e.g., unintended consequences of acting on compulsions and urges to avoid distressing situations)
Evidence: *TM*, Foa et al. (2012). *EO*, Veale et al. (2009).

Ability to demonstrate knowledge of functional analysis and its implications for treatment planning
Evidence: *OR*, Kim, et al. (2016); Foa and McLean (2016). *ThP*, Eelen and Van den Bergh, (2018); Huppert and Zlotnik, (2012). *TM*, Foa et al. (2012).

Ability to demonstrate knowledge of case formulation and its implications for treatment planning
Evidence: *OR,* Jacqueline and Lisa, (2015); Kuyken et al. (2008). *CES*, Nattrass et al. (2015); Zivor et al. 2013.

Ability to demonstrate knowledge of how to communicate assessment results to the patient in a clear and ethical manner
Evidence: *OR*, Foa (2010). *TM*, Foa et al. (2012); Sookman (2016).

Ability to demonstrate knowledge about the continuous nature of assessment through clinical data gathered from repeat administration of assessment measures, therapist observation and self-report, and ongoing assessment of adherence and response to treatment interventions
Evidence: *OR*, Foa (2010). *TM*, Foa et al. (2012). *EO*, Rapp et al. (2016).

Specialty Competencies:
Ability to take a complete history including developmental, familial, psychosocial, medical, psychiatric, and treatment history
Evidence: *TG:* Koran et al. (2007); American Psychiatric Association (2016). *TM:* Phillips and Stein (2014).

Ability to maintain the assessment focus despite symptom-related interference
Evidence: *CSS*, Parrish and Radomsky (2010). *CQS*, Halldorsson and Salkovskis (2017). *EO*, Pence et al. (2010).

Ability to direct specific questions to ascertain differential diagnoses
Evidence: *PS*, Osório et al. (2019); Sheehan et al. (1998). *TM*, Foa et al. (2012). *EO*, Rapp et al. (2016).

Ability to differentiate obsessions from other forms of repetitive thinking
Evidence: *PS*, Dar and Iqbal (2015).

AES, Langlois et al. (2000). *TM*, Foa et al. (2012).

Ability to differentiate obsessions from mental compulsions
Evidence: *PS*, Williams et al. (2011). *TM*, Foa et al. (2012). *EO*, Gillihan et al. (2012).

Ability to identify various levels of insight and differentiate between poor insight and delusional beliefs
Evidence: *OR*, Kozak and Foa (1994). *CS*, Catapano et al. (2010). *CSS*, Shavitt et al. (2014). *PS*, Eisen et al. (1998); Neziroglu et al. (1999).

Ability to evaluate the impact of symptoms on various life domains and developmental trajectory (e.g., self and child care, academic, vocational, social functioning)
Evidence: *MA*, Pozza et al. (2018). *CSS*, Challacombe et al. (2016). *PS*, Abbey et al. (2007); Huppert et al. (2009); Weidle et al. (2014).

Ability to collaboratively identify feared consequences and core fears. These include both external fears (e.g., harming) and internal fears (e.g., distress tolerance and appraisal, feared loss of cognitive-emotional control)
Evidence: *ThP*, Huppert and Zlotnik (2012). *TM*, Foa et al. (2012). *EO*, Benito and Walther (2015); Gillihan et al. (2012).

Ability to assess values and goals despite effects of chronicity on level of functioning and self-perception
Evidence: *CS*, Rowa et al. (2005). *CR*, Twohig et al. (2006). *ThP*, Huppert and Zlotnik (2012).

Ability to assess the differences between functional and dysfunctional resistance to obsessions and between realistic coping (e.g., COVID-19) and excessive compulsive behavior.
Evidence: *PS*, Deacon and Abramowitz (2005); Woody et al. (1995). *EO*, Fineberg et al. (2020); Thwaites and Freeston (2005).

Ability to assess suicidality risk while differentiating between suicidality and obsessions of self-harm
Evidence: *SR*, Albert et al. (2019). *CSS*, Velloso et al. (2016). *PS*, Beck et al. (1979).

Ability to assess secondary risk (i.e., of unintended consequences of acting on compulsions and urges to avoid distressing situations)
Evidence: *TM*, Foa et al. (2012). *EO*, Veale et al. (2009).

Ability to differentiate between culturally syntonic behaviors (e.g., religious compulsions) and compulsive behaviors that are excessive relative to the individual's cultural background
Evidence: *SR*, Nicolini et al. (2017). *PS*, Chasson et al. (2017). *AES*, Rosmarin et al. (2010).

Ability to communicate the results of the initial assessment to the patient in a clear and ethical manner
Evidence: *OR*, Foa (2010). *TM*, Foa et al. (2012); Sookman (2016).

Ability to use assessment information in case conceptualization and treatment planning and implementation, through the integration of clinical data from standardized scales, interview, and functional analysis
Evidence: *OR*, Foa and McLean (2016); Jacqueline and Lisa (2015); Kim et al. (2016); Kuyken et al. (2008). *CES*, Nattrass et al. (2015). *ThP*, Eelen and Van den Bergh (2018); Huppert and Zlotnik (2012). *TM*, Foa et al. (2012).

Ability to use assessment continuously throughout treatment in order to update its content and process in communication and collaboration with the patient
Evidence: *OR*, Foa (2010). *TM*, Foa et al. (2012). *EO*, Rapp et al. (2016).

3.2 Section Name: Case Conceptualization

Overview

The delivery of effective specialized CBT for OCD requires the therapist to have both a firm grasp of cognitive and behavioral principles as they apply to the development and maintenance of obsessions and compulsions (and accompanying difficulties) broadly and to the particular clinical presentation and context of the individual patient (Butler, 1998). The manner in which the cognitive behavioral principles apply to an individual patient with OCD is contained within the case conceptualization (CC). In this section, we describe the competencies relevant to the development of a CC for specialized cognitive behavioral treatment of OCD. Following Butler (1998), the CC is informed by the following:

Demographics including age, gender, education, occupation, ethnicity, family and social circumstances; description of the current difficulties including their impact on social and work-related functioning; history of the presenting complaint to include the precipitating events if known, the coping strategies adopted, and safety concerns; past mental health history including childhood experiences; developmental history including speech and social development that may clarify whether the OCD is comorbid with an Autistic Spectrum Disorder (ASD); family history of mental health problems; concerns and ideas that the patient may have about prognosis and treatability. The patient's understanding of their illness and degree of insight is also believed to play a role in its development (Ruscio et al. 2010), with the diagnosis in adulthood requiring that experience of symptoms be ego-dystonic.

CC is a developing process. The therapist and patient collaboratively update the CC with data obtained during treatment sessions, from homework assignments, and where necessary from family/significant others throughout treatment. The skill of the therapist in developing, presenting and revising the case conceptualization throughout treatment is hypothesized to play an important role in the development of a strong therapeutic alliance and positive expectancies about the delivered treatment, two "common factors" that are hypothesized to positively influence psychotherapy outcomes across conditions (Roth and Pilling, 2008). At the end of treatment a final CC may summarize the strategies learnt during treatment, to serve as a blueprint for preventing and managing any re-emergence of symptoms (Kuyken et al. 2009).

Definitions of key terms

Case conceptualization

Case conceptualization is the organization of information from interviews, observations and assessments using a well-founded theory so that the problem can be explained and hypotheses developed to inform the choice of intervention. In this instance, the case conceptualization is guided by cognitive behavioral principles. Predisposing, precipitating, perpetuating, and protective factors should be considered (Barker, 1983; John and Segal, 2016).

Ego-dystonic refers to the thoughts, feelings, and behaviors that are dissonant or inconsistent with the needs and goals of the person and their self-image.

Therapeutic alliance

Describes the collaborative relationship between patient and therapist to overcome the patient's problems. Bordin (1979) describes three elements: agreement on the goals of the treatment, agreement on the tasks, and the development of a personal bond made up of reciprocal positive feelings.

Strength of evidence

To date, no studies have been carried out that employ designs which allow reliable conclusions about whether the therapist's level of skill in CC is related to outcomes in CBT, including OCD, whether the treatment is delivered in research settings (trials) or routine care (Easden and Fletcher, 2020). However, good CC skills are often required for professional licensing. There is a widespread assumption that outcomes for CBT as delivered in routine care settings are often poorer than in treatment trials, and that this may partly reflect therapists having relatively little training and thus low use of case conceptualization in routine care (Kendjelic and Eells, 2007; Zivor et al. 2013; Huisman and Kangas, 2018). There is preliminary evidence that time-limited and low-cost training can improve the case conceptualization skills of clinicians with prior experience and knowledge of CBT for OCD (Zivor et al. 2013).

Available evidence robustly indicates that effective treatment of OCD requires specific psychotherapeutic interventions, for example exposure and plus response prevention, rather than common-factor influences (e.g., Strauss et al. 2019). Nonetheless, the case conceptualization represents an important tool in maintaining patient engagement in treatment and adapting evidence based CBT interventions to the specific circumstances of each patient (Hagen et al. 2016).

Recommendations for future research

Compared with the evidence for specialty interventions, the evidence on case conceptualization is sparse especially for obsessive compulsive and related disorders. It would be helpful to generate standards for training in case conceptualization and to identify minimum competencies for practitioners. Simultaneously, measures of clinical case conceptualization that allow for development over sessions could enable replicable processes. Further research is required to identify the strength of the influence of case conceptualization on providing the most effective specialty interventions for patients with OCD.

CASE CONCEPTUALIZATION **Specialty Knowledge:**
Ability to demonstrate knowledge of etiology of OCD including evidence for genetic transmission as distinct from family history. Example of questions: • **Do other members of the family have similar problems?** • **Are you aware of links with medical-health (probing for possible PANDAS)**
Evidence: *SR:* Hannigan, et al. (2017); Harvey et al. (2018). *OR:* Dougherty et al. (2018); O'Connell et al. (2018); Schultz (2019). *ThP:* Hezel and McNally (2016). *TM*: Sookman (2018).

Ability to demonstrate knowledge of components and questions required to develop a case conceptualization (please see assessment section of this paper for interview and psychometric contents for integrated conceptualization)
Evidence: *TM,* Koran, et al. (2007); APA (2016).

Ability to demonstrate knowledge of precipitating factors in OCD **Example of questions:** • **When did this problem first start?**

• **Are you aware of any particular event that might have been the cause? e.g. pregnancy, brain injury, bullying, changes in relationships, etc;** • **When did this problem first get noticed by yourself and others;** • **When did it cause distress;** • **When did it start to interfere with your life?**
Evidence: *CR,* Thompson et al. (2020).

Ability to demonstrate knowledge of theoretical models of OCD
Evidence: *OR,* Benzina et al. (2016); Hezel and MacNally (2016). *ThP,* Rachman (1998); Salkovskis (1999); Abramowitz et al. (2018).

Ability to demonstrate knowledge of OCD psychopathology, for example, difference between risky thoughts and risky behaviors and impact on case conceptualization
Evidence: *SR,* Albert et al. (2019). *CR,* Lewis et al. (2020); Edwards and Higham (2020).

Ability to demonstrate knowledge of difference between and impact on OCD of other co-morbidities, such as ASD, and impact on case conceptualization
Evidence: *OR,* Bejerot (2007); Wu et al. (2014). *CS,* Griffiths et al. (2017). *CC,* Zandt et al. (2007).

Ability to demonstrate knowledge of coping mechanisms in OCD
Evidence: *CSS,* Moritz et al. (2018).

Ability to demonstrate knowledge of integration of patient reported clinical data with theoretical perspectives to form a case formulation
Evidence: *TM,* Bream, et al. (2017); Clark (2019); Williams et al. (2019).

Ability to demonstrate knowledge of use of the case conceptualization in treatment planning
TM, Sookman (2016); Bream et al. (2017); Clark, (2019).

Ability to demonstrate knowledge of evolution of the case conceptualization in collaboration with the patient throughout treatment
TM, Sookman (2016); Bream et al. (2017); Clark, (2019).

Specialty Competencies:
Ability to identify individual differences in etiology and maintenance of OCD and related difficulties relevant to conceptualization of diverse symptom presentations
Evidence: *OR,* Schultz (2019). *CS,* van Oudheusden et al. (2018). *ThP,* Hezel and McNally (2016).

Ability to distinguish OCD and co-morbid psychopathology and impact on case conceptualization, for example, difference between ego-syntonic and ego-dystonic thoughts and behaviors and between risky and non-risky thoughts and behaviors
SR, Albert et al. (2019). *CR,* Lewis et al. (2020); Edwards and Higham (2020). *TM,* Foa, (2012).

Ability to develop a case conceptualization collaboratively with the patient that evolves throughout treatment
Evidence: *TG,* APA psychiatric case evaluation guidelines; Roth, and Pilling (2007); Beshai, et al. (2020). *RCS,* Strauss, et al. (2018). *CR,* Wheaton et al. (2016). *CQS,* Nattrass et al. (2015).

Ability to integrate the reported clinical data, theories of OCD, the evidence base, and case conceptualization to inform individualized application of interventions
Evidence: *SR,* Roth and Pilling (2008). *TM,* Sookman (2016); Bream et al. (2017); Clark, (2019).

3.3 Section Name: Psychoeducation

Overview

This section offers a summary of the key knowledge and clinical competencies required for offering psycho-education to patients with OCD. There is an emphasis on the treatment rationale for specialized cognitive behavior therapy (CBT) for OCD. The critical task for the clinician involves normalizing obsessions, highlighting the role of appraisals, and encouraging patients to collaborate in an optimal trial of specialized CBT, which will at times be distressing and challenging (Salkovskis, 1996; Sookman, 2016). The purpose of the psycho-education treatment component is to inform patients about the psychological mechanisms that maintain OCD symptoms such that this knowledge will support them in coping with often high levels of distress during CBT. Engagement is enhanced by patients' understanding of their illness, its developmental origins, and the psychological mechanisms that perpetuate the symptoms. Patients are informed that the purpose of CBT is not complete elimination of all intrusive thoughts or discomfort, but rather to develop a new and more helpful way of understanding their obsessions and of coping with them without compulsions (Veale and Willson, 2019). Development of a strong therapeutic relationship aims to

enhance the patient's ability to understand and to engage in treatment and to trust the therapist's support during distressing interventions (Kazantzis et al. 2017).

The psycho-education component may begin toward the end of the assessment phase when treatment recommendations are typically discussed. The initial psycho-education is considered the first treatment component following assessment, and usually lasts one or two sessions but occasionally longer. Treatment in the form of exposure and response prevention (ERP) or behavioral experiments does not begin until the psycho-education component has been completed. The quality of the therapeutic relationship is critical and sets the stage for ongoing productive collaboration between the patient and the therapist (or group therapists when treatment is offered in a group format).

Description of Key Terms

Psycho-education: A therapeutic intervention with a focus on the didactically skillful communication of key information within the framework of a cognitive-behavioral approach. The aim is that patients and their relatives be enabled to understand and accept the diagnosis of OCD and its treatment and begin to understand the nature of this illness and how to cope more successfully.

Therapeutic Relationship: An exchange between patient and therapist that develops for the purpose of sharing intimate thoughts, beliefs, and emotions in an endeavor to facilitate change. This relationship is generally characterized by a safe, open, nonjudgmental atmosphere that imbues trust and confidence adapted during therapist assistance in feared situations.

Key Components

Psycho-education is a critical component in the comprehensive treatment of OCD regardless of subtype of OCD and treatment format. Inaccurate or inadequate psycho-education can result in poor treatment adherence and outcome. The recommended approach does not differ depending on whether treatment is delivered in a group or individual setting; however, specific components such as involvement of family members necessarily require adjustment depending on treatment format and patient-specific factors.

As listed in the tabular knowledge section, key components include clinician's knowledge of the nature of obsession and their maintenance: through specific appraisals, attempts to neutralize the content of the obsessions by engaging in compulsive behaviors, avoidance, and reassurance seeking (Beck and Haig, 2014; Sookman, 2016).

Level of Evidence

Level of evidence for the required knowledge and competencies for psycho-education of OCD is high, including experimental research (e.g., Rachman et al. 2011), systematic reviews and neuroimaging twin studies (Van Grootheest et al. 2005), clinical case (Arch and Abramowitz, 2014), and naturalistic studies (Rachman and DeSilva, 1978; Veale et al. 2009).

Recommendations for Further Research

Further research in the area of psycho-education will be helpful in fine-tuning existing recommended practices but will also pose new important questions. For example, retention of psycho-educational material can be a challenge for some patients if they experience significant distress when first discussing their symptoms. Psycho-education is not a one-time only treatment

component but needs to be re-presented and discussed throughout treatment. Various optimization strategies such as presenting the treatment rationale more frequently and with enhanced formats may be necessary. Inclusion of a video or an app could potentially assist patients in better retaining the information and preparing for committing to treatment.

PSYCHOEDUCATION **Specialty Knowledge:**
Ability to demonstrate knowledge of a bio-psycho-social model of the aetiology of mental health disorders in general and specifically OCD
Evidence: *TM,* OCD-specific, Sookman (2016). *TrPN,* general psychopathology, Beck and Haig (2014).

Ability to demonstrate knowledge of genetic and neurobiological factors in the etiology of OCD
Evidence: *OR,* twin population studies, Van Grootheest et al. (2005). *CC,* neuroimaging case studies, Chamberlain et al. (2008); Saxena et al. (2009).

Ability to demonstrate knowledge of information processing factors (e.g, appraisals, distress) in the etiology of OCD
Evidence: *CR,* cognitive differences in OCD-afflicted persons vs. those without OCD, Matix-Cols and van den Heuvel (2012). *ThP,* child cognitive development, Bolton (1996).

Ability to demonstrate knowledge of psychosocial (environmental) risk factors for OCD
Evidence: *SR,* on the role of stressful life events, Brander et al. (2016).

Ability to demonstrate knowledge of common occurrence of obsessions and how obsessions often reflect important personal values
CR, naturalist studies with non-clinical samples, Rachman and DeSilva (1978); Veale et al. (2009).

Ability to demonstrate knowledge of the role of appraisals in attaching meaning to obsessions and how distress co-varies with personal meanings attached to content of intrusive thoughts
Evidence: *CSS*, comparing patients with OCD to anxious and non-clinical controls, OCCWG (2003, 2005). *ThP,* on the role of appraisals in attaching meaning to obsessions, Salkovskis (2009).

Ability to demonstrate knowledge of at least one cognitive model of OCD and the role of appraisals in perpetuating emotional distress, compulsions, avoidance, and other safety seeking behaviors
Evidence: *OR,* on the role of safety seeking behaviors, Blakey and Abramowitz (2016). *CR*, cases studies supporting the conceptual framework of the role of appraisals, Shafran et al. (2013). *CES,* laboratory experiments on role of appraisals in maintaining emotional distress, Rachman et al., (2011). *ThP,* conceptual understanding, Salkovskis (1996).

Ability to demonstrate knowledge about the rationale for exposure and response prevention, emphasizing both habituation and inhibitory learning
Evidence: *OR*, of inhibitory learning in exposure therapy with specific focus on OCD, Craske et al. (2014); Jacoby and Abramowitz (2016). *CES,* experimental vs. control groups in non-clinical samples, Lopatka and Rachman, (1995); Shafran, (1997). *ThP, CR,* conceptual model illustrated by clinical case studies, Salkovskis (1996); Arch and Abramowitz (2014); Benito and Walther (2015).

Specialty Competencies:
Ability to present at least one specific CBT model of OCD and discuss individual components, including normalizing obsessions, highlighting the critical role of appraisals, and discussing neutralizing behaviors including avoidance and reassurance seeking
Evidence: *TM,* treatment manuals for individual and group treatment based on research evidence, Foa and Wilson (2012); Söchting (2014); Sookman (2016).

Ability to communicate how neutralizing behaviors, whether overt or mental, offer temporary relief but perpetuate symptoms
Evidence: *TM,* e.g., how clinicians ought to educate patients about the vicious cycle of short-term relief but long-term maintenance of OCD symptoms, Veale and Willson (2019).

Ability to discuss the theory and rationale for exposure and response prevention treatment (ERP)
Evidence: *TM,* e.g., how clinician ought to prepare patients for exposure treatment, Foa and Wilson (2012).

Ability to discuss the theory and rationale for cognitive interventions, including behavioral experiments
Evidence:

TM, how to successfully implement cognitive interventions as warranted by OCD subtype, Wilhelm and Steketee (2006).

Ability to prepare patients for in-session, out of office, and home practice of ERP and/or behavioral experiments
Evidence: *TM,* for in-session cognitive interventions and behavioral experiment planning, Wilhelm and Steketee (2006) and for out of office exposure and home practice planning, Foa and Wilson, (2012); Sookman (2016).

Ability to work with patients' family members to minimize accommodation and maximize support and adherence for home practice
Evidence: *CQS, EO,* how to prepare family members for supporting treatment practice at home, Gomes et al. (2014); Sookman (2018).

Ability to make recommendations for length of treatment sessions based on understanding of an optimal treatment trial, including booster sessions as needed
Evidence: *TG, EO,* how to offer optimal length of treatment and booster sessions, Sookman and Steketee, (2010); Sookman (2016).

Ability to communicate the goal to patients of "becoming their own therapist" and to provide information on identification and coping with lapse or relapse
Evidence: *EO,* how to convey the critical concept of patients becoming their own therapists, Sookman, (2016).

Ability to form a strong therapeutic alliance and to foster a collaborative relationship
Evidence: *TM,* manual with a specific focus on the therapeutic relationship in CBT, Kazantzis et al. (2017). *EO,* on how to set the stage for early and ongoing patient-therapist collaboration, Gilbert and Leahy (2007).

Ability to promote patients' self-efficacy to improve ability to resist compulsions and to restore psychosocial functioning and quality of life
Evidence: *CS*, 115 patients were followed during inpatient administration of CBT, Schwartz et al. (2017). *ThP*, theoretical discussion of concept of self-efficacy, Bandura (1977). *EO*, how to increase motivation by encouraging patients to engage with meaningful and adaptive directions incompatible with OCD compulsions, Sookman (2016); Veale and Willson, (2019).

Ability to discuss risks and benefits of ERP, to determine patients' readiness and

motivation, and to communicate their right to withdraw from treatment at any time
Evidence: *TG*, how to successfully implement CBT and ensure optimal collaboration, Ledley et al. (2018).

Ability to 1) obtain informed consent following explanation of various treatment components in the therapist office, out of the office, and during home practice, 2) ensure that the patient has realistic expectations for treatment outcome (i.e., improvement of symptoms and functioning with aim of wellness or recovery where possible), and 3) discuss criteria that optimize outcome
Evidence: *TG*, on the general aspects of obtaining informed consent and they dynamic nature of such consent, Canadian Psychology Association Code of Ethics (2017); Evans (2004).

Ability to recommend self-help books that follow an evidence-based approach and to communicate how to use such books, i.e., not as a substitute for treatment
Evidence: *TG*, on how to support patient becoming their own therapist and maintaining treatment gains, Challacombe et al. (2011); Veale and Willson (2019).

3.4 Section Name: Exposure and Response Prevention and Behavioral Experiments

Overview
Exposure and response prevention (ERP or EX/RP) is a well-researched efficacious and effective behavioral intervention for OCD. This section outlines the key knowledge and competencies required for implementing EX/RP with patients with OCD.

Description of Key Term
In vivo exposure: Intentionally approaching people, places, situations, or objects that elicit obsessions and associated distress for therapeutic purposes.

Imaginal exposure: Exposure in imagination to feared disastrous consequences. Often used when in vivo exposure can't be realized because of real danger, legal, or ethical considerations. Also used to disconfirm patients' beliefs that thinking about the feared consequences will cause the consequence to materialize.

Response/Compulsion Prevention: Teaching patients how to stop engaging in compulsions (compulsions), particularly during exposure exercises. If necessary, patients may focus on preventing easier to resist compulsions first, and/or may be instructed in "spoiling" compulsions that were not successfully prevented by immediately engaging in an exposure.

Safety seeking behaviors: Any behavior (e.g., distraction, reassurance seeking, mental compulsions, symbolic compulsions) that interferes with the efficacy of exposure by limiting disconfirmation of the patient's beliefs that compulsions are necessary to prevent feared consequences.

Home visits: If practical and necessary, the therapist visits the patient's home to coach him/her in exposure exercises and compulsion prevention at home. Home visits may also be conducted through

videoconferencing.

Level of Evidence

EX/RP has been evaluated in case series, small controlled and uncontrolled trials, as well as several large randomized controlled trials including studies comparing EX/RP to other efficacious psychotherapies and antidepressant medications. Studies show that both exposure and response prevention are critical, and that treatment is effective in a variety of delivery schedules (e.g., weekly, twice-weekly, daily). Given the large body of research on EX/RP treatment that has accumulated over the past 30 years, several expert consensus guidelines recommend EX/RP and medication, alone or in combination, depending on the degree of symptom severity and impairment.

Recommendations for Further Research

The application of prominent theories, such as emotional processing theory, to OCD emphasizes the role of disconfirmation of feared consequences. However, research to confirm hypothesized mechanisms of change in EX/RP is required, including whether these mechanisms differ across OCD subtypes including patients with obsessions without overt compulsions.

EXPOSURE AND RESPONSE PREVENTION AND BEHAVIORAL EXPERIMENTS

Specialty Knowledge:

Ability to demonstrate knowledge of the theoretical background of EX/RP

Evidence:
OR, Meyer et al. (1974).
CR, Foa (1979).
ThP, Foa and Kozak (1986); Rachman (1976); Foa and McLean (2016).

Ability to demonstrate knowledge of the differential effects of exposure and response prevention and the need to implement both components

Evidence:
MA, Abramowitz (1996).
RCT, Foa et al. (1984); Rachman et al. (1971).

Ability to demonstrate knowledge of patient preference for graduated approach to exposure over 'flooding'

Evidence:
CC, Hodgson et al. (1972); Rachman et al. (1971).

Ability to demonstrate knowledge of why and how to integrate imaginal exposure

Evidence:
RCT, Foa et al. (1980); Foa et al. (1984); Foa et al. (1985); Ito et al. (1995).

Ability to demonstrate knowledge of the efficacy of EX/RP

Evidence:
TG, Greist et al. (2003); NICE (2006); Koran and Simpson (2013).
MA, Hofmann and Smits (2008).
RCT, Fals-Stewart et al. (1993); Marks et al. (1980); Marks (1981); Rachman et al. (1971); Lindsay et al. (1997); Cottraux et al. (2001); McLean et al. (2001); Whittal et al. (2005); Foa et al. (1998).
RCS, McLean et al. (2015).
CS, Franklin et al. (2000); Rothbaum and Shahar (2000); Warren and Thomas (2001).
OCT, Valderhaug et al. (2007).

Ability to demonstrate knowledge of the efficacy of EX/RP and serotonin reuptake inhibitors for OCD alone and in combination
Evidence: *SR,* Foa et al. (2002); Foa et al. (2005). *RCT,* Foa et al. (2005), Foa et al. (2013); Simpson et al. (2008); Simpson et al. (2013); Tenneij et al. (2005). *OCT,* Kampman et al. (2002); Tolin et al. (2004). *CC,* Franklin et al. (2002).

Ability to demonstrate knowledge of who should and should not receive EX/RP (i.e., OCD should be the primary diagnosis when comorbid diagnoses are present)
Evidence: *CC,* Foa et al. (1999); Abramowitz and Foa (2000); Abramowitz et al. (2000).

Ability to demonstrate knowledge of when and how to implement home visits during EX/RP
Evidence: *TM,* Foa et al. (2012).

Ability to demonstrate knowledge of utility of adding motivational interviewing to EX/RP
Evidence: *RCT,* Simpson et al. (2010). *OCT,* Simpson et al. (2008).

Ability to demonstrate knowledge of options for EX/RP session frequency
Evidence: *RCT,* Abramowitz et al. (2003).

Ability to demonstrate knowledge of ethical concerns and solutions in implementing exposure therapy, particularly out of office exposures and home visits
Evidence: *OR,* Altis et al. (2014). *TrPN,* Olatunji et al. (2009); Wolitzky-Taylor et al. (2012).

Ability to demonstrate knowledge of EX/RP efficacy with different OCD symptom subtypes
Evidence: *SR,* Ball et al. (1996). *OR,* Williams et al. (2013). *RCS,* Mataix-Cols et al. (2002); Chase et al. (2015). *CS,* Rufer et al. (2006); Williams et al. (2014). *CSS + CS,* Abramowitz et al. (2003).

Ability to demonstrate knowledge of the importance of homework adherence
Evidence: *RCS,* De Araujo et al. (1996); Simpson et al. (2011); Wheaton et al. (2016). *CS,* Abramowitz et al. (2002). *OCT*, Tolin et al. (2004).

Specialty Competencies:
Ability to explain the rational for EX/RP to patients in a clear and compelling fashion
Evidence: *TM,* Abramowitz (2006a); Foa et al. (2012). *TrPN,* Rowa et al. (2007); Abramowitz and Arch (2014).

Ability to instruct and support patients in identifying triggers, obsessions and compulsions (e.g. avoidance, washing, cognitive compulsions)
Evidence: *TM*, Foa et al. (2012); Abramowitz (2006a). *TrPN,* Rowa et al. (2007).

Ability to generate and order vivo and imaginal exposure
Evidence: *TM,* Foa, Yadin, and Licnher (2012); Abramowitz (2006a). *TrPN,* Rowa et al. (2007); Abramowitz and Arch (2014); Pence et al. (2010).

Ability to instruct patients in response prevention and how to re-expose oneself if a compulsion is conducted
Evidence: *TrPN*, Rowa et al. (2007).

Ability to implement home visits during EX/RP when feasible and appropriate

Evidence: *TM,* Foa et al. (2012); Abramowitz (2006a).

Ability to identify criteria to implement imaginal exposure to help patients confront disastrous consequences that they fear will occur if they abstain from compulsions
Evidence: *TM,* Foa et al. Licnher (2012); Abramowitz (2006a). *TrPN,* Rowa et al. (2007), Gillihan et al. (2012), Pence et al. (2010).

Ability to encourage patients to approach all feared situations to maximize gains and reduce risk of relapse
Evidence: *TM*, Foa et al. (2012); Abramowitz (2006a). *TrPN*, Gillihan et al. (2012); Abramowitz and Arch (2014).

Ability to identify and effectively address subtle safety seeking behaviors (e.g., distraction, reassurance seeking, mental compulsions, symbolic compulsions) that may be interfering with the efficacy of exposure and disconfirming the patient's beliefs that compulsions are necessary for their safety
Evidence: *TM*, Foa et al. (2012); Abramowitz (2006a). *TrPN*, Gillihan et al. (2012); Pence et al. (2010); Arch and Abramowitz (2015).

Ability to frame exposures as hypothesis testing and implement post-exposure processing to help patient attend to and articulate learning that took place during the exposure
Evidence: *TM*, Abramowitz (2006a). *TrPN*, Gillihan et al. (2012); Arch and Abramowitz (2015).

Ability to plan and conduct home visits (when feasible) to support the transfer of treatment gains to the patient's home environment
Evidence: *TM*, Foa et al. (2012); Abramowitz (2006a). *TrPN,* Gillihan et al. (2012).

Ability to employ standard and idiographic psychoeducational handouts, monitoring forms, and homework recording forms to help patients engage in EX/RP
Evidence: *TM,* Abramowitz (2006a).

Ability to select and implement appropriate assessment tools to gather information about breadth and severity of OCD symptoms (e.g., Y-BOCS) and OCD-related insight (BABS), and to select and use appropriate self-report measures (e.g., OCI) to plan treatment and monitor progress during EX/RP

Evidence: *TG,* Koran and Simpson (2013). *TM,* Foa et al. (2012); Abramowitz (2006a).

Ability to use behavioral experiments to test expectations about consequences of abstaining from compulsions to provide the patient with evidence from their own experience about the accuracy of maladaptive thoughts and behaviors, and to reduce compulsions
Evidence: *OR,* Abramowitz (2006a). *TM,* Abramowitz (2006b). *TrPN,* Abramowitz and Arch (2014); Arch and Abramowitz (2015).

Ability to modify EX/RP for different ages, cultures, and other patient-specific characteristics
Evidence: *RCT,* Simons et al. (2006); Bolton and Perrin (2008). *CS,* Friedman et al. (2003). *CR,* Franklin et al. (2001); Price and Salsman (2010).

Ability to teach family/other support persons how to support the patient's EX//RP efforts without accommodating their OCD symptoms (please see family-based interventions in this paper)
Evidence: *RCT,* Emmelkamp et al. (1990); Emmelkamp and de Lange (1983); Mehta (1990), van Noppen et al. (1991); van Noppen et al. (1997); Grunes et al. (2001). *TM*, Foa et al. (2012); Abramowitz (2006a). *TrPN,* Gillihan et al. (2012).

3.5 Section Name: Inhibitory and Learning Theory Models of Exposure Therapy

Overview
An inhibitory and learning theory model of exposure therapy emphasize associative learning processes, such as extinction learning, as a principal mechanism of exposure therapy. Rather than focusing on within or between session reductions in fear, a learning theory model emphasizes interventions that enhance the acquisition, consolidation, generalization, and retrieval of extinction learning (e.g., Craske et al. 2008). This model of exposure therapy is based on decades of research in both animals and humans, as well as the overall validity of an associative learning model in the genesis, maintenance, and treatment of anxiety-related disorders (see below)

As described in the tabular overview, competency standards for targeting extinction learning through exposure therapy require a clinician to be aware of several key processes, as well as the

supporting animal and human literature. These include, but are not limited to, a) knowledge of extinction learning as an error-correction mechanism, b) knowledge of the impact of "safety behaviors" on extinction learning, c) knowledge of strategies for maximizing extinction learning, and d) the ability to design and conduct exposures consistent with a learning theory model. Additional competencies are outlined in the tabular overview.

Level of Evidence

There is strong evidence for extinction learning as an important mechanism of exposure therapy. This level of evidence is derived from several factors. First, there is considerable evidence that individuals with anxiety-related disorders, included obsessive-compulsive disorder (OCD), demonstrate deficits in associative learning compared to healthy controls (e.g., Geller et al. 2017; Lissek et al. 2009; Milad et al. 2013), and that these deficits predict the emergence of psychopathology (Lommen et al. 2013). Thus, in addition to face validity, there is evidence for the construct and predictive validity of an associative learning model.

In regard to extinction learning as a mechanism of exposure therapy, there is good evidence that extinction learning, and its neurobiological substrates, change as a result of exposure therapy (Helpman et al, 2016; Kircher et al. 2013; Lueken et al. 2013). In addition, there is evidence that specific genetic substrates of extinction learning predict response to exposure therapy for OCD (Fullana et al. 2012) and other anxiety disorders (e.g., Felmingham et al. 2013). Finally, pharmacological agents known to target extinction learning enhance response to treatment (e.g., Kushner et al. 2007; Smits et al. 2013).

In addition, the translational applications of extinction learning to exposure therapy (e.g., Craske et al. 2008) are based upon an extremely strong empirical evidence base regarding mechanisms of extinction learning, derived from decades of research in both animals and humans (e.g., Bouton, 2004, Culver et al. 2015; Rescorla, 2006).

Although research will continue to delineate the role of associative learning processes in exposure therapy for OCD, the extant literature currently supports the notion that extinction learning is a mechanism of exposure therapy, and it is suggested that clinicians target extinction learning during treatment.

Recommendations for Further Research

Despite the strong evidence for an associative learning model of exposure therapy, there is a need for additional research to more firmly establish extinction learning as a principal mechanism, and the optimal parameters for targeting extinction learning during treatment.

For example, although there is evidence that extinction learning changes as a result of treatment, and that changes in extinction learning co-vary with symptom improvement (e.g., Helpman et al, 2016; Kircher et al. 2013; Lueken et al. 2013), this needs to be replicated across additional laboratories and clinical samples (including OCD).

In addition, it will be important to measure extinction learning throughout treatment (or at least mid way through treatment), in order to provide stronger evidence that changes in extinction learning drive changes in symptoms. Measuring extinction learning alongside additional mechanisms (e.g., habituation) will provide further evidence for the specificity of associative learning processes as a principal mechanism of exposure therapy. However, this is true of numerous evidence-based

interventions, as very few studies have sufficiently measured treatment mechanisms, let alone multiple potential mechanisms simultaneously (Kazdin, 2007).

Future research should also examine the optimal parameters for targeting extinction learning during exposure therapy. The extant literature in animals and humans has identified several behavioral strategies that enhance extinction learning. However, future research that examines the effect of manipulating these strategies during exposure therapy will be informative.

INHIBITORY AND LEARNING THEORY MODELS OF EXPOSURE THERAPY

Specialty Knowledge:

Ability to demonstrate knowledge of modern learning theory conceptualizations of obsessive-compulsive disorders and exposure therapy

Evidence:
SR, Craske et al. (2008); Craske et al. (2012).
ThP, Craske et al. (2014); Sewart and Craske (2020).
EO, Arch and Abramowitz (2015).

Ability to demonstrate knowledge of translational research supporting changes in associative learning as a potential mechanism of exposure therapy

Evidence:
SR, Craske et al. (2008); Craske et al. (2012); Lipp et al. (2020).
CES, Fullana et al. (2012); Felmingham et al. (2013); Gellar et al. (2019); Helplman et al. (2016); Kircher et al. (2013); Kushner et al. (2007); Lueken et al. 2013; Lange et al. (2020); Smits et al. (2013).
AES, Brown et al. (2016); Deacon et al. (2013).
ThP, Craske et al. (2014).

Ability to demonstrate knowledge of dominant models of associative learning, with an emphasis on the role of error correction or expectancy violation in learning (e.g., extinction learning)

Evidence:
SR, Craske et al. (2008); Craske et al. (2012); Lipp et al. (2020).
ThP, Craske et al. (2014); Sewart and Craske (2020).
AR, Rescorla and Wagner (1972).

Ability to demonstrate knowledge of research demonstrating the negative impact of avoidance behavior/conditional inhibitors on extinction learning

Evidence:
SR, Craske et al. (2008); Craske et al. (2012).
AES, Lovibond et al. (2009).
ThP, Craske et al. (2014); Sewart and Craske (2020).
AR, Rescorla (1969).

Ability to demonstrate knowledge of extinction enhancement strategies including deepened extinction, variability, occasional reinforced extinction, spacing of extinction/exposure trials, and increased attentional salience of the conditional stimulus
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012); Lipp et al. (2020). *AES,* Culver et al. (2015); Lang and Craske (2000); Scheveneels et al. (2019); Struyf et al. (2018); Vansteenwegen et al. (2007); Zbozinek and Craske (2018). *ThP,* Craske et al. (2014); Sewart and Craske (2020). *AR,* Bouton et al. (2004); Leung et al. (2012).

Ability to demonstrate knowledge regarding the resistance of evaluative processes (e.g., emotions such as disgust) to traditional extinction learning, and the potential efficacy of counterconditioning procedures in targeting evaluative processes
Evidence: *AES,* Baeyens et al. (1988); Engelhard et al. (2014), Kerkhof et al. (2011); Vansteenwegen et al. (2006).

Specialty Competencies:
Ability to conceptualize cases from a learning theory perspective, with an emphasis on identifying unconditional stimuli, conditional stimuli, safety seeking behaviors/conditional inhibitors, and modulatory variables
Evidence: *ThP,* Craske et al. (2014).

Ability to provide rationale behind exposure therapy, with an emphasis on expectancy violation
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012); Lipp et al. (2020). *ThP,* Craske et al. (2014); Sewart et al. (2020). *AR,* Rescorla and Wagner (1972).

Ability to provide psychoeducation regarding the role of safety seeking behaviors in reducing extinction learning
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012). *AES,* Lovibond et al. (2009). *ThP,* Craske et al. (2014); Sewart and Craske (2020). *AR*, Rescorla (1969).

Ability to assess and increase motivation to engage in exposure therapy
Evidence: *RCT,* Buckner and Schmidt (2009); Maltby and Tolin (2005).

CR, Riccardi et al. (2009). *TM,* Miller and Rollnick (2012).

Ability to identify the principal unconditional stimulus (US)
Evidence: *ThP,* Craske et al. (2014).

Ability to identify the principal conditional stimulus (CS) -- that is, the ability to identify the stimulus that is the strongest predictor of the US
Evidence: *ThP,* Craske et al. (2014). *AR,* Bouton et al. (2012); Holland (1989); Rescorla (1986).

Ability to identify relevant safety seeking behaviors/negative occasion setters/conditional inhibitors that reduce expectancy
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012). *ThP,* Craske et al. (2014); Sewart and Craske (2020).

Ability to assess factors that increase expectancy of US (e.g., contextual variables). For example, the expectancy of a US may only occur when the CS is presented for a particular period of time (e.g., illness is only expected if an individual touched a perceived contaminated surface for a specific period of time)
Evidence: *ThP,* Craske et al. (2014).

Ability to design in vivo exposures to maximally violate expectancy. This includes, but is not limited to, the following: • **Ensuring that the principal conditional stimulus is selected for the exposure** • **Ensuring that the target unconditional stimulus is identified and operationalized in a manner that patient will be aware of its non-occurrence (e.g., harming one's infant may be specifically operationalized as drowning them while bathing)** • **Ensuring that any relevant contextual variables (e.g., duration of CS contact) that increase expectancy are present during the exposure** • **Ensuring that any safety behaviors/conditional inhibitors that reduce expectancy are removed during exposure**
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012). *ThP,* Craske et al. (2014); Sewart and Craske (2020). *AR,* Rescorla and Wagner (1972).

Ability to assist patient in consolidating extinction learning following an exposure. This includes questions, in person or via a worksheet, such as "What did you expect would happen as a result of doing the exposure?", "What happened?", "You predicted that X (the US) would occur. Did it? How do you know"? This "mental rehearsal" of the non-contingent relationship between the CS and US may enhance consolidation of the extinction memory
Evidence: *AES,* Joos (2012); Meeter and Murre (2004). *ThP,* Craske et al. (2014).

Ability to flexibly employ various extinction enhancement strategies (e.g., deepened extinction, variability, trial spacing, attentional salience of the CS, removing of safety signals, occasional reinforced extinction, etc.) as appropriate
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012); Lipp et al. (2020). *AES,* Culver et al. (2015); Lang and Craske (2000); Scheveneels et al. (2019); Struyf et al. (2018); Thompson et al. (2018); Vansteenwegen et al. (2007). *ThP,* Craske et al. (2014). *AR,* Bouton et al. (2004); Leung et al. (2012).

Ability to design exposures to continually enhance expectancy violation over the course of treatment. This includes the ability to add relevant contextual variables or stimuli (e.g., deepened extinction) that increase expectancy throughout treatment
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012). *ThP,* Craske et al. (2014).

Ability to incorporate variability in exposures, in order to increase generalization of learning, while simultaneously maintaining a focus on expectancy violation
Evidence: *SR*, Craske et al. (2008); Craske et al. (2012). *AES,* Lang and Craske (2000); Scheveneels et al. (2019); Vansteenwegen et al. (2007). *ThP,* Craske et al. (2014); Sewart and Craske (2020).

Ability to design imaginal exposures in a manner consistent with expectancy violation or stimulus discrimination • **This includes the ability to identify a relevant US predicted to occur as result of imaginal exposure (e.g., inability to function as a result of the distress of conducting the imaginal exposure; having the thought/image of being ill increases likelihood of contracting illness)**
Evidence: *SR,* Tsodyks and Gilbert (2004). *ThP,* Craske et al. (2014).

Ability to handle continued avoidance or lack of compliance with exposure homework
Evidence: *CES,* Glenn et al. (2013); Simpson, et al. (2011). *TM,* Miller and Rollnick (2012).

Ability to structure additional treatment interventions (e.g., cognitive restructuring) so that they do not negatively impact extinction learning
Evidence: *ThP*, Craske et al. (2014).

Ability to identify components of conditional reactions (e.g., evaluative responses such as disgust) that may be more resistant to extinction learning, and to effectively convey this information to clients
Evidence: *AES*, Baeyens et al. (1988); Englehard et al. (2014); Kerkhof et al. (2011); Vansteenwegen et al. (2006).

3.6 Section name: Cognitive Therapy Part 1

Overview
This section describes the knowledge and competencies recommended to deliver specialty CBT for OCD using the model of Salkovskis (1985, 1999). There is abundant evidence that intrusive thoughts are common in the general population, but for most people they are not distressing and are easily dismissed. Central to this model is the idea that a threatening appraisal of the occurrence and/or content of intrusive thoughts drives a range of reactions including emotion, attention, safety-seeking behaviors (SSBs) and avoidance. These in turn serve to reinforce the credibility of the initial appraisal and increase the frequency of the intrusions. CBT using this model is based on gaining a shared understanding of the person's specific appraisals and maintaining factors in an individualized formulation. Detailed knowledge of the various forms of OCD and the range of overt and covert SSBs are required to deliver this model. Knowledge of obsessional beliefs that can be contributing to the problem including but not confined to responsibility is required. Key competencies focus on eliciting the details of an individual's intrusions and appraisals, mapping out the full range of their reactions and conveying how these serve to maintain the problem using formulation skills. Competence is required in eliciting intrusions and appraisals, particularly those associated with shame.

The next phase of CBT using this model is presenting and examining the problem as one of excessive fear rather than one of danger in terms of evidence, associated behaviors and implications for the future. The person moves to testing out these competing theories using behavioral experiments and then building on this new knowledge to reduce compulsions and avoidance. Relevant competencies here are the ability to use socratic questioning to help the person understand that their thoughts are normal and the ability to increase motivation to drop counter- productive SSBs. The ability to design behavioral experiments that clearly test the theories is key. Competencies also include motivating the person to engage in these experiments using discussion techniques and therapist modelling, detecting blocks during experiments such as subtle avoidance and SSBs, and helping the person take responsibility for their progress. In specialty CBT using this model, particular attention is placed on the meaning of experiments and exposure tasks in terms of change in appraisals and beliefs.

Description of Key Terms
Safety-seeking behavior: behaviors designed to avert a feared outcome or reduce anxiety, that

reinforce and/or prevent disconfirmation of the threat appraisal.

Vicious flower: The diagrammatic representation of the idiosyncratic OCD formulation including trigger, appraisal and a series of 'petals' representing each process that reinforces the threat appraisal.

Level of Evidence

There is published evidence in support for this specific model in a small number of case series and RCTs, but only against waitlist control groups. There is good support for the central tenets of the model from experimental and clinical literature.

Recommendations for Further Research

Larger trials could elucidate whether this model is equally effective for all major types of OCD. There is little longer term follow up data on people treated with this approach. Further research could also explore the relationship between this model and the limited use of safety-seeking behaviors given the emphasis on belief change rather than on exposure.

COGNITIVE THERAPY PART 1 **Specialty Knowledge:**
Ability to demonstrate knowledge of a wide range of presentations of OCD – e.g., concerns about contamination, checking, religion / blasphemy, relationships, harm to self or others
Evidence: *CS,* Haldorsson and Salkovskis (2017); Rector et al (2019). *ThP*, Salkovskis (1999). *TM*, Bream et al. (2017).

Ability to recognize a wide range of safety seeking behaviors, including covert, overt, and very subtle forms
Evidence: *ThP*, Salkovskis (1991); Freeston et al. (1996). *TM*, Bream et al. (2017).

Ability to demonstrate knowledge that the negative appraisal of intrusive thoughts – often believing that they are responsible for preventing harm -- leads to distress and generates the need to engage in compulsive behavior as protection, restitution or to prevent harm
Evidence: *CS*, Purdon and Clark (1994). *CES,* Forrester et al. (2002); Salkovskis et al. (2003); Salkovskis et al. (1997); Wroe et al. (2000). *ThP,* Salkovskis (1985). *TM*, Bream et al. (2017).

Ability to demonstrate knowledge of relevant common OCD beliefs, including inflated responsibility, overimportance of thoughts, overestimation of threat, intolerance of uncertainty, perfectionism, and 'not just right experiences'
Evidence: *CS,* Olatunji et al (2019). *CC,* Wahl et al. (2008). *ThP,* Coles et al. (2003); OCCWG (1997). *TM*, Bream et al. (2017).

Ability to demonstrate knowledge of the specific role of responsibility
Evidence: *CS*, Barrett et al. (2016). *CC*, Cougle et al. (2007); Wroe and Salkovskis (2000). *PS,* Salkovskis et al. (2000). *CES,* Ladouceur et al. (1995); Leonhart et al. (2019); Wroe et al, (2000); Leonhart and Radomsky, (2019). *ThP*, Salkovskis et al. (1999).

Ability to demonstrate knowledge of the counterproductive nature of safety seeking behaviors, including avoidance and attentional bias
Evidence: *CS,* Freeston et al. (1991). *CES,* Salkovskis and Campbell (1994); Salkovskis et al. (2003); Salkovskis and Kobori (2015); Van den Hout et al. (2019). *TP*, Salkovskis (1991).

Ability to formulate thoughts, negative appraisal, emotion, and counterproductive strategies as a 'vicious flower'
Evidence: *CS,* Natrass et al. (2015) *CSS,* Zivor et al. (2013); Zivor et al. (2013). *ThP* Salkovskis (1999). *TM*, Bream et al. (2017).

Ability to plan treatment based on the cognitive conceptualization
Evidence: *ThP* Salkovskis (1999). *TM*, Bream et al. (2017).

Ability to demonstrate knowledge of strategies for how to guide the person with OCD through treatment to 'becoming their own therapist'in order to optimize generalization and maintenance of change
Evidence: *TM*, Bream et al. (2017).

Ability to demonstrate knowledge of strategies to plan for effective relapse prevention (e.g., reinstitution of specific strategies under stress)
Evidence: *TM*, Bream et al. (2017).

Specialty Competencies:
Engagement • **Ability to normalize intrusive thoughts – occurrence and content -- drawing on pertinent examples for the specific problem** • **Ability to use Socratic questioning to establish that no thought is bad; OCD emerges due to the appraisal of the thought** **Ability to describe and explain the rationale for specialty cognitive therapy and respond to queries**
Evidence: *CS*, Shepherd et al. (2009). *TM*, Bream et al. (2017).

Motivation / barriers to change

- **Ability to express understanding of and to address barriers to change in terms of motivation, distress, chronicity of problem, perceived probability of the occurrence of feared outcome and its 'awfulness'**
- **Ability to use metaphor and Socratic questioning to enhance willingness to change**
- **Ability to develop a list of goals that represent reclaiming of the aspects of life that OCD has affected**

Evidence:
TM, Bream et al. (2017).

Active intervention

- **Ability to collaboratively develop an idiosyncratic 'vicious flower' formulation that elucidates the counterproductive nature of all safety-seeking behaviors**
- **Ability to identify and formulate OCD-relevant beliefs, including inflated responsibility, overimportance of thoughts, overestimation of threat, intolerance of uncertainty, perfectionism, and 'not just right experiences'**
- **Ability to identify the influence of comorbid or complicating other problems on reported experience and formulate accordingly**
- **Ability to collaboratively develop a credible alternative understanding of the problem (Theory A/B)**
- **Ability to explore the person's current and past experiences to build up evidence for each alternative (Theory A/B) and the implications of acting according to each belief**
  Ability to collaboratively devise behavioral experiments that are approachable and useful in building up evidence for theory B and against theory A – to test their beliefs
- **Ability to facilitate approach toward distressing situations and to increase tolerance of high distress without engaging in overt or covert avoidance, neutralizing, or other compulsive behaviors**
- **Ability to undertake therapist modeling – be prepared to do and exceed any behavioral experiment (within normal limits) including 'anti-OCD' – e.g., putting hands in the toilet to challenge contamination fears, wishing death on own loved ones to challenge magical thinking**
- **Ability to collaboratively agree upon appropriately challenging cognitive therapy homework for each stage of treatment and to follow up on the homework in each session**
- **Ability to facilitate patient responsibility for planning further behavioral experiments**
- **Ability to detect and challenge any covert shifting of responsibility and other dysfunctional beliefs and related feelings**
- **Ability to detect and challenge other covert safety seeking behaviors and avoidance in behavioral experiments**
- **Ability to manage complications that might arise, such as extreme reluctance to engage in behavioral experiments**

Evidence: *RCT*, Bolton et al. (2011); Challacombe et al. (2017); Williams et al. (2010). *OCT,* Oldfield et al. (2011). *CSS,* Zivor et al. (2013); Zivor et al. (2013). *CR,* Challacombe and Salkovskis (2011). *TM,* Bream et al. (2017).

Relapse prevention • **Ability to work with the person with OCD to identify times of heightened responsibility -- e.g. becoming a parent, leaving home, taking a promotion / responsible job, when the likelihood of relapse may increase** • **Ability to plan what steps would be necessary to regain progress in the event of a relapse, including doing 'anti-OCD' behavioral experiments and reviewing key sessions** • **Ability to set trajectory of progress with person with OCD to work on their longer-term goals**
Evidence: *TM*, Bream et al. (2017).

3.7 Section Name: Cognitive Therapy Part 2

Overview

Contemporary cognitive treatment for OCD originates with Salkovskis, 1985 (see cognitive therapy part I, this paper) and was based on the understanding that ego dystonic intrusions are experienced by a substantial portion of the population. As such, it is not the intrusion that is the problem but the meaning that is attributed to the intrusion, that is, the appraisal. Additionally, the interest in cognitive treatments arose out of attention to the drop out rates associated with treatments that relied on exposure and response prevention (ERP). It was hoped that cognitive treatments would be more easily tolerated and improve upon the established efficacy rates.

Theorists associated with the appraisal model focused on different aspects of appraisal and belief in developing areas for study and treatment strategies. For example, Salkovskis and colleagues targeted inflated responsibility (e.g., Salkovskis, 1985) whereas others worked on the overestimation of danger (e.g., Jones and Menzies, 1998). Rachman (2002) focused on appraisals associated with the overimportance of thoughts (e.g., "mad, bad, dangerous"). Relatedly, Purdon and Clark (2002) focused on the need to control thoughts. Other researchers targeted perfectionism and the intolerance of uncertainty (e.g., Frost et al. 2002). Early treatment trials incorporating a cognitive component (e.g., Emmelkamp and Beens, 1991) showed promise and were further refined following the seminal Salkovskis (1985) paper in addition to the collaborative effort of the Obsessive Compulsive Cognitions Working Group (OCCWG 1997, 2001, 2005). Freeston (e.g., Freeston et al. 1996), van Oppen et al. (1995) and others published early theoretical papers and case studies elucidating treatment strategies that were subsequently combined into treatment packages and tested in later randomized trials (e.g., van Oppen and Arntz, 1994; McLean et al. 2001).

Definition of Key Terms

Thought action fusion (Shafran et al. 1996) – This is a process whereby a thought is seen to be more likely because it occurred. Likelihood thought action fusion can be directed toward others (e.g., the

thought of loved ones dying in an accident increases the probability of it occurring) or the self (e.g., a thought of becoming ill increases the probability that it will occur). Moral thought action fusion is the equating of thought and action morally (e.g., the thought of harming a loved one is estimated to be as morally bad as doing it).

Paradox of thought control – This is based upon the thought suppression work of Dan Wegner (i.e., the white bear suppression effect). If a thought is appraised in a negative personally relevant way, a common strategy to neutralize it would be efforts at suppressing the thought. The work of Wegner and others highlights that thought suppression can result in a rebound effect such that it increases attention to the thoughts, which results in experiencing an increased frequency of unwanted intrusions.

Responsibility Pie – To address the black and white thinking associated with responsibility (e.g., 'it will be all my fault'), responsibility pies are used to identify all possible sources/people with whom the person can share the responsibility (responsibility is not absolute, it is a shared phenomenon). Subjective responsibility is initially established, and then other factors are identified and the estimated responsibility associated with each factor should the fear consequence occur is put into the pie. Once other factors are considered, the responsibility associated with the individual with OCD is placed into the remainder of the pie.

Overestimating threat – To assist with jumping to conclusions (e.g., 'if I leave the stove on I will start a fire and burn the house down) and making logical estimations of threat/danger, a table is used where all factors prior to the final feared consequence are listed and the probabilities associated with each of these steps are identified. In a behavioral experiment the subjective probability which is established prior is compared to the logical probability with the aim of disconfirmatory learning.

Intolerance of uncertainty – This refers to the subjective negative emotions experienced in response to the unknown aspects of a given situation (Dugas et al, 1995; Freeston et al. 2020). Thus, for some individuals, it is not the threat of feared consequences but not knowing. This may be "aleatory" uncertainty that we cannot know in advance (rather than epistemic uncertainty, where some facts are known, but there is ambiguity). It is not the valence of what happens; simply the unknowingness. This may lead to trying to obtain further information or checking, but this is usually doubtful or contradictory and leads to further doubts and intolerance of uncertainty.

Level of Evidence

There is an established base of evidence for this cognitive treatment package which has been tested in numerous randomized controlled trials (e.g., van Oppen et al. (1995); McLean et al (1999); Whittal et al. 2005 and 2008). Although there are subtle differences between research groups, cognitively focused treatments are associated with strong effect sizes that are durable. van Oppen and colleagues published data from a 5-year follow-up study (van Oppen et al. 2005), and Whittal et al (2008) reported a 2-year follow-up study from their group and individual RCTs. Treatment effects were generally maintained over time. Research suggests that cognitively focused treatments may be better tolerated for some cases compared with behavioral interventions (Whittal et al. 2008), and improve treatment response when combined wirh ERP compared with ERP alone (Rector et al, 2019).

Recommendations for Further Research

An important research question is to what extent and for whom combined treatment including

cognitive and behavioral treatment strategies would be optimal. Combination interventions are likely needed for many adults in order to address the complexity of symptom presentations. There are several evidence-based cognitive therapy models and interventions that may be differentially helpful contingent on the heterogeneity of OCD presentations. The evidence-based competencies outlined in this section may not be helpful for some patients and symptom subtypes. For example, dysfunctional beliefs characteristic of some subtypes are not characteristic of others for which metacognitive and other interventions may be helpful (Taylor et al. 2006; Solem et al. 2009). Further research is indicated on promising conceptual and treatment approaches to consider broader developmental learning experience that may maintain intransigent current patterms (Beck, 1996; Beck and Haigh, 2014). These include schema-based approaches, and imagery rescripting of distressing past memories, developed specifically for OCD (Sookman et al. 1994, 2003; Salkovskis et al. 1999; Rachman et al, 2015; Veale et al. 2015). An aim of these approaches is to improve patients' collaboration with evidence based behavioral interventions. Importantly, adaptive strategies for identification, tolerance, modulation, and reappraisal of emotions appear critical to ameliorate varied OCD experience and distress (e.g., disgust, incompleteness) and require further study (Sookman, 2016; Wei, et al. 2020). An inference-based approach (IBA, O'Connor et al. 2005; Visser et al. 2015) may be helpful for some patients who present with pervading doubt and poor insight. Given the heterogenous nature of OCD, ongoing development and refinement of specialty treatment protocols are strongly advocated for specific subtype presentations elaborated in this paper.

COGNITIVE THERAPY PART 2

Specialty Knowledge:

Ability to prepare a case conceptualization including[1]

- **Predisposing factors (e.g., unpredictable childhood secondary to parental instability, peer bullying, and/or early illness of patient)**
- **Precipitating factors (e.g., current interpersonal stressor such as illness in self or family member, accident in the home, hearing about a catastrophic event such as a fire that happened to someone else)**
- **Maintaining factors (i.e., compulsions, neutralizations, and/or avoidance)**

Evidence:

RCT, Emmelkamp and Beens (1991); van Oppen et al. (1995, 2005); McLean et al. (2001); O'Connor et al. (2005); Whittal et al. (2008); Visser et al. (2015); Rector et al. (2018).
CR, van Oppen (2004); Jassie et al. (2018); Radomsky et al. (2019); Radomsky et al. (2019).
ThP, Salkovskis (1985,1999); van Oppen and Arntz (1994); Julien et al. (2016).

Ability to demonstrate knowledge of psychoeducation regarding at least one cognitive model of OCD (connection between thoughts/intrusions/doubts, mental compulsions, emotions, and behavior)

Evidence:

OR, Julien et al. (2007).
RCT, Whittal et al. (2010).
CC, O'Connor and Robillard (1995).
CSS, Salkovskis and Kobori (2015).
CR, van Oppen (2004).
CES, Forrester et al. (2002); Baretta and Norton (2011).
AES, Freeston et al. (1991); Ladouceur et al. (1995); Cougle et al. (2007).
TM, Salkovskis (1985,1999); van Oppen and Arntz (1994,1995); Purdon and Clark (1994). Salkovskis and Campbell (1994); Salkovkis et al. (1997); Salkovskis et al. (2000).

Ability to demonstrate knowledge of OCD-specific cognitive therapy competencies for the appraisal/beliefs model

a. Initial steps

- **Psychoeducation to the model emphasizing differences between intrusions, mental compulsions, and negative automatic thoughts/appraisals/meaning of the intrusion and connection to overt or covert compulsions (compulsion/neutralization)**
- **Normalizing intrusions**
- **Downward arrow to identify worst case and/or core fears**
- **Cognitive reappraisal using Socratic method**
- **In-session behavioral experiments (e.g., demonstration of the paradox of thought control – the white bear suppression effect)**

Evidence:

OR, Julien et al. (2016).
RCT, Emmelkamp and Beens (1991); van Oppen et al. (1995, 2005); McLean et al. (2001); Whittal et al. (2008).
CES, Forrester et al. (2002).

[1] Relevant to treatment planning for specialty cognitive therapy and other interventions for OCD described in this paper

AES, Rachman and di Silva (1978); Salkovskis and Harrison (1984); Freeston et al. (1991); Purdon and Clark (1994); Salkovskis and Campbell (1994); Ladouceur et al. (1995); Cougle et al. (2007).
ThP, Whittal et al. (2010).
TM, Salkovskis (1985,1999); van Oppen and Arntz (1994); Rachman (2002).

b. Overestimation of threat and inflated responsibility
- **Responsibility piecharting**
- **Transfers of responsibility experiments**
- **Threat experiments**
- **Probability estimations**
- **Surveys**

o **Overimportance and need to control thoughts**
- **Paradox of thought control**
- **Behavioral experiments (e.g., difference between desire and fear of desire)**
- **Letting thoughts come and go**
- **Surveys (e.g., list of nonclinical obsessions experienced by others and attributions of meanings)**
- **Use of continuums (e.g., good person/bad person)**
- **Thought action fusion (experiments, challenging)**

o **Perfectionism and certainty**
- **Multidimensional reappraisal (e.g., broadening patients' definition of what it means to be a good mother)**
- **Normalizing uncertainty (certainty is not possible and comparison to 'risk' taking in other areas of life -- e.g., riding/driving a car, flying)**
- **Use of metaphor**
- **Use of surveys (e.g., how common is it for people who don't have OCD to be certain that their door is locked)**

Evidence:
CC, Grisham and Williams (2013).
CSS, Salkovskis and Kobori (2015).
AES, Wegner et al. (1987); Salkovkis et al. (1997; 2000).
TM, Whittal et al. (2002); Yule and Whittal (2007; in press); Whittal and Robichaud (2012).

Specialty Competencies:

Ability to collaborate with the patient in "guided discovery" and to structure the session (relevant to other CBT interventions)
- **Agenda setting**
- **Homework review with assessment of adherence**
- **Practicing in-session cognitive therapy techniques**
- **Collaboration on homework**

Evidence:
CR, van Oppen and Arntz (1994); van Oppen (2004).
CQS, Sheperd et al. (2009).
ThP, Salkovskis (1985); Zivor et al. (2013), Zivor et al. (2013).

TM, O'Connor and Aardema (2011); O'Connor et al. (2014).

Ability to identify and explain current symptoms including predisposing, precipitating, and maintaining factors, and to communicate case conceptualization relevant to cognitive therapy planning
Evidence: *ThP,* Salkovskis (1985); van Oppen and Arntz (1994).

Ability to orient the patient to at least one cognitive model for OCD and to explain the relationship between intrusions, appraisals, emotion, and behavior
Evidence: *ThP,* Whittal et al. (2010). *TM,* O'Connor and Aardema (2011); Julien et al. (2016).

Ability to provide psychoeducation specifically to the cognitive model for OCD, including the ubiquity of unwanted thoughts
Evidence: *AES,* Rachman and de Silva (1978); Salkovskis and Harrison (1984). *ThP,* Whittal et al. (2010).

Ability to identify the cognitive domains relevant for each patient and their relationship to appraisals and beliefs
Evidence: *PS,* Obsessive Compulsive Cognitions Working Group (1997, 2004). *ThP,* Whittal and McLean (1999). *TM,* Frost et al. (2002); Purdon and Clark (2002); Salkovskis and Forrester (2002); Sookman and Pinard (2002); Thordarson and Shafran (2002) .

Ability to use the formulation as a guide for decision making regarding which cognitive domains to target during treatment
Evidence: *EO,* Persons et al. (1996).

Ability to advise and provide feedback to patients as they identify triggers, appraisals, and compulsive behaviors with reference to the cognitive therapy conceptual model
Evidence: *RCT,* Van Oppen et al. (1995); McLean et al. (2001); Whittal et al. (2008); Whittal et al. (2010). *ThP,* Freeston et al. (1996); Whittal and McLean, (1999).

Ability to design and use surveys to collect personally relevant information with the goal of normalizing intrusions and appraisals
Evidence: *ThP,* Whittal and McLean (1999). *TM,* Whittal and Robichaud (2012); Rachman et al. (2014).

Ability to design and implement behavioral experiments to provide corrective information with the goal of developing adaptive appraisals
Evidence: *ThP,* Salkovskis (1985); Salkovskis et al. (1999). *TrPN,* van Oppen and Arntz (1994); Freeston et al. (1996).

Ability to use cognitive behavioral strategies to modify appraisals so that the meaning of intrusions no longer engenders distress and the need to engage in compulsions
Evidence: *ThP,* Whittal and McLean (1999); Whittal and Robichaud (2012).

3.8 Section Name: Family-Based Interventions for OCD

Overview
Family responses to OCD, such as Family Accommodation (FA) and Expressed Emotion (EE), have gained prominence in the literature as mediators in the course and treatment of OCD. Given their impact on the course of the disorder and treatment outcome, there is impetus to develop effective family-based treatments for OCD.

Though there are reports of family-based interventions in the treatment of adults dating back four decades, more recent investigations have focused on pediatric samples. The American Psychiatric Association OCD practice guideline indicates the importance of family factors in OCD treatment outcomes (APA, 2007). The NICE Clinical Guidelines (2006) state: "When family members or carers of people with OCD or BDD have become involved in compulsive behaviors, avoidance or reassurance seeking, treatment plans should help them reduce their involvement in these behaviors in a sensitive and supportive manner." Shimshoni et al. (2019) searched for available, peer-reviewed, English language papers, published between September 2015 and March 2018, cross-referencing psychiatric disorders with accommodation and other family-related terms (Shimshoni et al. 2019). Ninety-one papers were identified and reviewed, of which 69 were included in this review. In OCD, family accommodation has been repeatedly linked to greater OCD symptom severity, personal and family functional impairment, caregiver burden, and poorer treatment outcomes. Several randomized controlled trials explored the efficacy of different family- based treatments aimed at reducing family accommodation and OCD symptom severity (Baruah et al. 2016).

Description of Key Terms
Family accommodation in OCD specifically refers to providing reassurance, participating in compulsions, modifying personal and family routines, facilitating avoidance, and taking on the patient's responsibilities (Calvocoressi et al. 1995). Intrusiveness, poor role definition, and a lack of boundaries are characteristic in families with a high degree of accommodation (Calvocoressi et al. 1995). Calvocoressi and colleagues (1997) reported that family accommodation was present for 88% of spouses or parents and correlated significantly with patient symptom severity and global functioning, family dysfunction, and relatives' reported distress. Although accommodation to OCD symptoms may seem benevolent, relatives' excessive accommodation to compulsions contradicts exposure-based therapy, may perpetuate and reinforce symptoms, and may increase relatives' feelings of distress (Steketee et al. 1998). Family accommodation has been a reliable and replicated predictor of poorer treatment outcome (as reviewed by Shimshoni et al. [2019]). The concept of

Family Accommodation was first published in the clinical literature in 1990 (Livingston-Van et al.). Three validated versions of the Family Accommodation Scale are in the public domain: FAS-Interview Rated (Calvocoressi et al. 1995), FAS- Self Rated (Pinto, Van Noppen, and Calvocoressi, 2013) and FAS- Patient Version (Wu et al. 2016). These three versions of the FAS have been translated in over 15 languages and are available at: https://publichealth.yale.edu/familyaccommodationocd/

Expressed emotion (criticism, hostility, and emotional overinvolvement) is recognized as a robust factor for reliably mediating course or relapse in psychiatric illnesses (for a historical review on expressed emotion see Barrowclough et al. 1994; Brown and Rutter, 1966; Hooley and Licht, 1997). Expressed emotion reflects the emotional quality of interactions that occur between relatives and a psychiatric patient, linking family reactions to patient functioning (for a review relevant to OCD, see Steketee et al. 1998). Berardis et al. [2008]) explored the relationship between insight and expressed emotion as this potentially relates to treatment outcome.

Level of Evidence

Amir et al. (2000) noted the relationship of family accommodation with treatment outcome. OCD patients with relatives who accommodated and modified their schedules more had lower response rates to behavioral therapy. In a path-analytic model, Van Noppen and Steketee (2009) found that of all the family variables examined, family accommodation made the largest contribution to predicting OCD symptom severity. Family accommodation has been consistently shown to correlate with OCD symptom severity.

The importance of family in the course of the disorder and treatment has been prominent but not well developed in controlled studies (for a review see Steketee and Van Noppen (2009). Bressi and Guggeri (1996) suggested that interventions specifically aimed at improving strategies of families dealing with an adult with OCD should target relatives' perceptions of patient behavior and their emotional and behavioral responses to the behavior. A family-based approach to treatment underscores the fact that OCD is embedded in a family context, highlighting the important dynamic between relative responses and the patient's distress level and functioning. The findings from studies on family accommodation and expressed emotion indicate that these family responses have gained attention as a fundamental predictor of OCD treatment outcome and should be targeted foci of family-based treatment (Baruah et al. (2018), Remmerswaal et al. (2016), Van Noppen, et al. (1997), Van Noppen et al. (1997).

Recommendations for Further Research

Specialized CBT including ERP is a robust and effective treatment for OCD with or without medication. It may be necessary to consider combined treatment with medication, or the use of techniques to enhance the efficacy of CBT-ERP, to speed treatment response or for treatment resistant patients. Family accommodation and expressed emotion are important topics for the clinician to be aware of, and evidence suggests that attention to these topics results in improvement of OCD symptoms. We are in need of randomized, controlled studies to further understand the motivation behind family accommodation, the relationship to symptom subtypes, how family accommodation interferes with ERP, and cultural influences on family accommodation. Further, controlled treatment trials are needed to develop an efficacious, standardized family-based OCD intervention to target different foci of family accommodation. Some patients report distressing relationship obsessions, including pathological jealousy, that merit further interventional study (Doron and Derby, 2017; Melli et al. 2018; Brandes et al., 2020).

FAMILY-BASED INTERVENTIONS FOR OCD

Specialty Knowledge:

Ability to demonstrate knowledge of basic background on systems, structural, strategic, family theories

Evidence:
SR and TrPN, Boss et al. (2004).
TM, Mueser and Glynn (1999).
TrPN, Madanes, (1991); Titleman, (2013).

Ability to demonstrate knowledge of OCD, and impact of family accommodation (FA) on the course and treatment outcome of OCD

Evidence:
MA, Thompson-Hollands et al. (2014).
SR, Lebowitz et al. (2012); Lebowitz et al. (2016); Shimshoni et al. (2019).
SR and *TrPN*, Sassano et al. (2015).
RCT, Baruah et al. (2018).
CES, Abramowitz et al. (2012); Amir et al. (2000); Gomes et al. (2014); Remmerswaal et al. (2016).

Ability to demonstrate knowledge of Expressed Emotion (EE) concepts and impact on course and treatment of OCD

Evidence:
SR, Steketee et al. (1998*).*
RCT, Chambless, and Steketee (1999).
*CES, (*general psychiatry), Barrowclough et al. (1994); Brown and Rutter, (1966); Hooley and Licht, (1997); (OCD specific), Bressi and Guggeri, (1996); Berardis et al. (2008); Emmelkamp et al. (1992).

Ability to demonstrate knowledge of family behavioral contracting

Evidence:
CES, TM, Van Noppen, (2002); Van Noppen, (2015); Van Noppen, and Steketee, (2001); Van Noppen et al. (1997); Van Noppen et al. (1997).

Specialty Competencies:

Ability to provide assessment and treatment planning to: identify which family members to include in treatment, assess family structure and relationships, and administer family accommodation assessments

Evidence:
OR, Livingston-Van Noppen et al. (1990); Steketee and Van Noppen (2003); Van Noppen and Steketee (2003).
PS, Calvocoressi et al. (1999); Pinto et al. (2013); Wu et al. (2016).
CES, Van Noppen et al. (1997).
TM, Van Noppen, (2002); Van Noppen, (2015); Van Noppen, and Steketee, (2001).

Ability to provide psychoeducation to explain family accommodation and expressed emotion and the impact on the course of OCD/ERP
Evidence: *OR,* Livingston-Van Noppen et al. (1990); Steketee and Van Noppen, (2003); Van Noppen and Steketee (2003). *CES,* Van Noppen et al. (1997). *TM,* Van Noppen, (2002); Van Noppen, (2015); Van Noppen, and Steketee, (2001).

Ability to administer family-based intervention: create a family-based hierarchy, administer in-vivo contracting, devise homework ERP contracts, execute problem solving, modify family contracts
Evidence: *OR,* Livingston-Van Noppen et al. (1990); Steketee and Van Noppen (2003); Van Noppen, and Steketee (2003). *CES,* Van Noppen et al. (1997). *TM,* Van Noppen, (2002); Van Noppen, (2015); Van Noppen and Steketee (2001).

Ability to identify and intervene on barriers – e.g., how to work with a family when the patient refuses to engage in treatment, how to offer family-based treatment with the patient alone when family refuses to engage or is hostile toward the patient
Evidence: *TrPn,* VanDyke et al. (2015).

3.9 Section Name: Homework

Overview
Treatment-related homework is an essential component in the acquisition of new learning and skills (via behavioral and cognitive techniques), generalization of new learning to existing and novel situations, and maintenance of learning after formal treatment has ceased. Although data regarding the impact of homework compliance on outcomes in OCD specifically is limited, there is nevertheless support for the benefits of homework in outcomes with CBT more generally. This section outlines the knowledge and competencies of OCD homework.

Description of Key Terms
Homework: Therapy work completed by the patient independently outside of the formal therapy setting, designed to aid in new learning and skill acquisition, generalization of new learning to existing and novel situations, and maintenance of gains after formal treatment has ended.

Homework types: OCD Homework can take many forms including behavioral (e.g., exposure and response prevention [ERP], behavioral experiments) cognitive techniques (e.g., reappraising maladaptive thoughts and responses, imaginal exposure, mindfulness), strategies for emotional distress, and symptom monitoring/assessment.

Homework adherence: Adherence is the extent to which patients implement the recommended homework (Abramowitz et al. 2002; Anand et al, 2011), time spent (i.e., quantity), quality of

homework (e.g., completing ERP trials as prescribed (Kazantzis et al. 2016), and success with response prevention (Wheaton et al. 2016).

Level of Evidence

Few studies have assessed the role of homework in OCD. Simpson et al. (2011) assessed the role of homework *adherence* on treatment outcome using the Patient EX/RP Adherence Scale (PEAS; Simpson et al. 2010). Wheaton et al. (2016) and Kazantzis et al. (2016) explored the *attributes* (i.e., quantity, quality, response prevention) of homework on treatment outcomes whereas Abramowitz et al. (2002) focused on how factors such as response prevention, self-monitoring of compulsions, understanding the treatment rationale, and homework compliance relate to post-treatment symptom severity. Reviews and book chapters (Clark, 2007; Franklin, 2005) are sources for understanding the clinical application of homework including discussions of common barriers to homework compliance (Huppert et al. 2006). Farrell et al. (2013) used an experimental design comparing two groups of clinicians to explore how therapist factors, and more specifically therapist perceptions of the safety, tolerability, ethicality of exposure work, may influence how ERP is delivered and communicated to patients. A recent treatment outcome study assessed the role of therapist and non-therapist coaches vs no coach on a web-based treatment intervention (Kobak et al. [2015]). Other technological interventions have been evaluated to enhance homework compliance and treatment outcome (Whiteside et al. (2014); Vogel et al. (2011). Lastly, family factors such as symptom accommodation (Morgan et al. 2013) and treatment expectations (Lewin et al. 2011) can impact treatment compliance.

Recommendations for Further Research

A limited number of empirical studies have assessed the role of homework in OCD. The use of homework appears to be of value in enhancing treatment outcome, although some types of homework may be better tolerated than others. Research focusing on the attributes and differential impact of homework types (e.g., ERP, imaginal exposure, mindfulness, thought reappraisal, behavioral experiments, distress tolerance strategies) on homework compliance is needed. Understanding barriers to treatment (e.g., time, energy, motivation, understanding, etc.) at the outset might lead to improved homework fidelity. Further, the use of technology in the form of web-based treatment protocols, monitoring applications (i.e., apps), or phone support may help to improve homework adherence.

Efforts to clarify the specific characteristics of homework such as “dose”, quality, and compliance with response prevention would help provide prescriptive guidelines for how homework is assigned. For example, there is currently no accepted daily or weekly “dose” of homework prescribed by clinicians. Therapist factors may have a significant influence on how ERP and homework is explained and delivered. Future research assessing the impact that therapist anxiety and perceptions of the safety, tolerability, and ethicality of ERP would be of value. Lastly, family factors such as symptom accommodation, perceptions of ERP, parental anxiety, etc., may impact motivation, homework adherence, and ultimately outcomes. Understanding how family factors impact homework compliance, especially in children and teens, could help to inform efforts to educate and prepare families at the outset of treatment.

HOMEWORK

Specialty Knowledge:

Ability to demonstrate knowledge of the role that homework plays in the treatment of OCD (e.g., definition of homework, outcomes, benefits)

Evidence:
RCT, Marks et al. (1988); Park et al. (2014); Simpson et al. (2011); Wheaton et al. (2016).
RCS, De Araujo et al. (1996); Kenwright et al. (2005); Simpson et al. (2011).
CS, Abramowitz et al. (2002); Anand et al. (2011); LeBeau et al. (2013); Woods et al. (2002).
CS, CR, Vogel et al. (2012).

Ability to demonstrate knowledge of the different types of homework (e.g., ERP, imaginal exposure, cognitive restructuring, monitoring, behavioral experiments)

Evidence:
TM, Clark (2007); Franklin (2005); Sookman and Steketee (2010).
TrPN, CR, Hudson and Kendall (2002); Huppert et al. (2006).

Ability to demonstrate knowledge of the elements (e.g., quantity, quality, compulsion prevention) of homework for OCD

Evidence:
MA, Kazantzis et al. (2016).
RCT, Wheaton et al. (2016).
RCS, Simpson et al. (2011).
CS, Woods et al. (2002).
PS, Simpson et al. (2010).
EO, Foa and Kozak (1986).

Ability to demonstrate knowledge of how to assess homework compliance (e.g., PEAS, monitoring)

Evidence:
RCT, Lewin et al. (2011); Park et al. (2014); Wheaton et al. (2016).
RCS, Olatunji et al. (2015); Simpson et al. (2011).
CS, LeBeau et al. (2013); Woods et al. (2002).
PS, Simpson et al. (2010).

Ability to demonstrate knowledge of the barriers to homework compliance (e.g., safety behaviors, time, energy, motivation, ASI, anticipatory anxiety, expectations)

Evidence:
CR, Weidle and Skarphedinsson (2016).
TrPN, Huppert et al. (2006).

Ability to demonstrate knowledge of how to overcome barriers or create modifications to homework (e.g., tech aids, phone support, goal setting, contingencies)

Evidence:
SR, Lind et al. (2013) .
RCT, Marks et al. (1988).

RCS, Kenwright et al. (2005); Kobak et al. (2015). *CS,* Vogel et al. (2012). *CR,* Whiteside et al. (2014). *TrPN*, Huppert et al. (2006).

Ability to demonstrate knowledge of the role of family, caregivers, and school personnel in homework compliance implementation and maintenance
Evidence: *RCT*, Lewin et al. (2011); Morgan et al. (2013). *CR*, Weidle and Skarphedinsson (2016).

Ability to demonstrate knowledge of patient and therapist perceptions of homework and ERP homework (e.g., therapist anxiety, beliefs about ERP)
Evidence: *RCS*, Farrell et al. (2016). *CES*, Farrell et al. (2013).

Ability to demonstrate knowledge of homework in relapse prevention (i.e., long term benefits of homework compliance)
Evidence: *RCT,* Marks et al. (1988). *CS*, Anand et al. (2011). *CR*, Farrell et al. (2016).

Ability to demonstrate knowledge of reappraisal of meanings assignments (e.g., behavioral experiments) as component of homework
Evidence: *CR,* McKay (2016). *TM*, Sookman and Steketee (2010).

Specialty Competencies:
Ability to communicate the role/rationale/benefits of homework as part of treatment
Evidence: *MA,* Kazantzis et al. (2004). *RCS,* De Araujo et al. (1996). *CS,* LeBeau et al. (2013). *PS,* Anand et al. (2011); Simpson et al. (2010). *TrPN, CR*, Hudson and Kendall (2002); Huppert et al. (2006).

Ability to identify and assign the different types of homework using individualized collaborative process (monitoring, ERP, imaginal exposure, behavioral experiments, bibliotherapy)
Evidence: *RCS,* De Araujo et al. (1996).

CS, Anand et al. (2011). *TrPN*, Huppert et al. (2006).

Ability to communicate the expectations for homework in terms of quantity, quality, and compulsion prevention
Evidence: *MA*, Kazantzis et al. (2016). *RCT,* Marks et al. (1988); Wheaton et al. (2016). *RCS,* De Araujo et al. (1996); Simpson et al. (2011). *CS,* Woods et al. (2002). *TrPN,* Huppert et al. (2006). *TrPN, CR*, Hudson and Kendall (2002). *EO,* Foa and Kozak (1986).

Ability to utilize strategies to assist with patient monitoring and recording of homework
Evidence: *CS*, Abramowitz et al. (2002); Woods et al. (2002). *TrPN, CR*, Hudson and Kendall (2002).

Ability to inform patient regarding the potential benefits of using a homework coach
Evidence: *RCT,* Marks et al. (1988). *RCS*, Kenwright et al. (2005); Kobak et al. (2015). *CS,* Anand et al. (2011).

Ability to identify and collaboratively address patient barriers to homework compliance/adherence (e.g., motivation, time, energy, lack of understanding, resistance) and therapist barriers (e.g., therapist anxiety, therapist beliefs about ERP)
Evidence: *RCS*, Farrell et al. (2016). *CR*, Weidle and Skarphedinsson (2016). *CES*, Farrell et al. (2013).

Ability to communicate the benefits of homework for successful treatment outcome and maintenance of treatment gains
Evidence: *RCT*, Marks et al. (1988); Park et al. (2014). *CS*, Abramowitz et al, (2002); Anand et al. (2011); LeBeau et al. (2013); Woods et al. (2002). *TrPN,* Huppert et al. (2006).

Ability to identify and address possible patient misperceptions of homework that could impede adherence
Evidence: *RCS*, Simpson et al. (2011). *TrPN, CR*, Hudson and Kendall (2002).

Ability to administer strategies to enhance compliance, including therapist modelling, goal setting, and use of rewards
Evidence: *CR*, Weidle and Skarphedinsson (2016). *ThP,* Huppert et al. (2006).

Ability to maximize the generalizability of exposure work to include completing homework in a variety of settings
Evidence: *CR*, Weidle and Skarphedinsson (2016). *TrPN,* Huppert et al. (2006).

Ability to determine the expectations for time spent on homework each day (e.g., two hours per day, seven days per week) and/or number of exposure trials (e.g., 5 trials of 5 exposures)
Evidence: *RCT,* Marks et al. (1988). *RCS,* De Araujo et al. (1996).

Ability to communicate how a homework assignment is to be completed
Evidence: *RCT,* Marks et al. (1988). *CS*, Abramowitz et al. (2002); Woods et al. (2002). *TrPN,* Huppert et al. (2006).

Ability to assign developmentally adapted homework
Evidence: *RCT*, Park et al. (2014). *CR*, Weidle and Skarphedinsson (2016). *TrPN, CR*, Hudson and Kendall (2002).

Ability to communicate the basic elements of ERP trials (e.g., gradual, repetitive, prolonged)
Evidence: *RCT*, Marks et al. (1988); Simpson et al. (2011); Wheaton et al. Simpson (2016).

Ability to inform patients on the role of safety behaviors/compulsion prevention during homework and their impact on treatment outcome
Evidence: *RCS*, Simpson et al. (2011).

Ability to demonstrate how exposure homework is to be completed via therapist modeling
Evidence: *RCT,* Marks et al. (1988).

RCS, Farrell et al. (2016).
CES, Farrell et al. (2013).
TrPN, Huppert et al. (2006).

Ability to educate family members on the role of homework in treatment

Evidence:
RCT, Park et al. (2014).
CS, Anand et al. (2011).
CR, Farrell et al. (2016); Weidle and Skarphedinsson (2016).
TrPN, CR, Hudson and Kendall (2002).

Ability to identify and administer strategies for homework noncompliance, including incomplete homework assignments, doing more homework than was assigned, doing exposure without compulsion prevention, suboptimal habituation and/or inhibitory learning, engaging in safety behaviors

Evidence:
ThP, Huppert et al. (2006), Craske at al., (2014)
TM, Franklin (2005).

Ability to utilize collaboration of family members and others to promote homework compliance

Evidence:
RCT, Marks et al. (1988).
CS, Anand et al. (2011).
CR, et al. (2016).
TrPN, CR, Hudson and Kendall (2002).

Ability to identify and administer strategies for family accommodation behaviors that interfere with motivation to complete homework

Evidence:
CR, Weidle and Skarphedinsson (2016).
TrPN, CR, Hudson and Kendall (2002).

Ability to assess homework compliance using established measures

Evidence:
RCT, Wheaton et al. (2016).
RCS, Simpson et al. (2011).
CS, Anand et al. (2011).
PS, Simpson et al. (2010).

Ability to identify and address the impact of co-morbid conditions such as depression, ADHD, autism spectrum disorder, anxiety disorders, substance use, etc., on patients' ability to understand, implement, complete, and/or benefit from homework

Evidence: *RCT*, Park et al. (2013).

Ability to identify and address barriers to homework completion, including lack of time, low energy, motivation, anxiety sensitivity, anticipatory anxiety, beliefs about exposure, dysfunctional beliefs, intolerance of distress
Evidence: *RCT*, Lewin et al. (2011). *TrPN,* Huppert et al. (2006).

Ability to assign cognitive restructuring and distress tolerance homework (e.g., related to perceived threat, need for certainty, importance and control of thoughts, behavioral experiments)
Evidence: *CS*, Anand et al. (2011). *TM*, Sookman and Steketee (2010) .

Ability to assign homework to maintain treatment gains/manage relapse
Evidence: *RCT*, Simpson et al. (2011) *TrPN,* Huppert, Ledley, Foa (2006)

Knowledge and Competency Standards for Specialized CBT for Adult OCD: Part II

3.10 Section Name: Contamination (Including Mental Contamination)

Overview

One of the most common forms of OCD is compulsive cleaning and washing, driven by a fear of contamination (Veale and Roberts, 2014). This section outlines the key knowledge and competencies required for working with patients with OCD-related contamination fears.

Description of Key Terms

Contact contamination: Feelings of dirtiness, pollution, or disgust that arise following direct physical contact with a tangible stimulus. These feelings are predominately experienced externally on the skin and are responsive to washing.

Mental contamination: Feelings of dirtiness, pollution, or disgust that arise without physical contact with a tangible stimulus. The source of contamination is human, rather than inanimate, and the feelings of dirtiness and pollution are predominately internal and consequently may be less responsive to washing.

Morphing: Also known as 'transformation obsessions.' The fear of taking on the undesirable characteristics of an unsavoury person(s) and, in extreme cases, transforming into them. The type of

person classed as undesirable is both personally and culturally defined but may include personal enemies or people who are considered "weird," dirty, or of low status.

Contamination following violations or betrayals: Feelings of contamination can be caused by psychological or emotional violations, without any physical contact. This may include degradation, humiliation, and betrayals (Rachman, 2010).

Contamination arising from intrusive thoughts, images and impulses: Intense feelings of internal contamination can be caused by the occurrence of unwanted, intrusive, repugnant thoughts or impulses, or by one's unacceptable actions. The intrusive thoughts that give rise to self-contamination resemble obsessions (Rachman, 2003), and the two can overlap.

Visual contamination: Contamination feelings can occur following the sight of something or someone viewed as immoral, disreputable, or bizarre.

Level of evidence

The majority of evidence for contamination in OCD is based on key theoretical papers (e.g., Rachman, 2004; Rachman, 2006; Rachman et al. 2014), which have been substantiated by experimental research (including the induction of mental contamination) using mainly analogue or samples with subclinical OCD (e.g. Elliott and Radomsky, 2009, 2012; Ishikawa et al. Shimizu, 2014; Rachman et al. 2012; Radomsky and Elliott, 2009). There are also a number of clinical papers reporting on contamination and its treatment (including questionnaire or qualitative data) in patients with OCD (e.g. Coughtrey et al. 2012; Coughtrey et al. 2012). In terms of treatment, there are a number of large randomised controlled trials of both exposure and response prevention and cognitive behavioral therapy for OCD which have included patients with contamination fears (e.g. Pooniah et al. 2013). More recently there has been a case series of cognitive behavioral therapy for mental contamination specifically (Coughtrey et al. 2013). There is evidence that the experience of disgust is less responsive to ERP and more resistant to extinction compared with other contamination related experience, and is characterized by differential physiological responses compared with fear (e.g., Mason and Richardson, 2012; Duncko and Veale, 2016; for review see Mancusi et al., 2017).

Recommendations for Further Research

Further experimental and clinical evidence for the cognitive theory of contamination is required, including the classification of the different forms of contamination fears. It is likely that patients with mental contamination fears are less responsive to exposure and response prevention for OCD, as the source of the contamination is internal and often intangible. Future research will benefit from sub-analyses of the effectiveness and acceptability of ERP for patients with contamination fears and further investigation of the effectiveness of cognitive-behavioral therapy for mental contamination through randomised controlled trials. Further research is needed on treatment approaches that have been proposed specifically for disgust, such as counter conditioning, inhibitory learning models of ERP, and cognitive reappraisal strategies (Craske et al., 2014; Engelhard et al. 2014; Wong et al. 2021).

CONTAMINATION (INCLUDING MENTAL CONTAMINATION) **Specialty Knowledge:**
Ability to demonstrate knowledge of the theoretical background to the acquisition of contamination according to different theoretical models -- e.g., habituation, inhibitory fear learning, three pathways to fear, and appraisal-based learning
Evidence: *ThP*, e.g. habituation, Foa and Kozak (1986); Watts (1979), inhibitory fear learning, Craske et al. (2004); Craske et al. (2008); Jacoby and Abramowitz (2016), three pathways to fear, Rachman, (1977), and appraisal based learning, Clark (2004; Frost and Steketee (2002); Salkovskis (1985).

Ability to demonstrate knowledge of, define, and recognise, (a) contact contamination and (b) mental contamination
Evidence: *ThP,* e.g. contamination fears, Rachman (1994); Rachman (2006); Rachman et al. (2015); Rachman and Hodgson (1980).

Ability to demonstrate knowledge of the different forms of (a) contact contamination -- e.g., radiation, asbestos, AIDS; and (b) mental contamination -- e.g. following betrayals, morphing, visual contamination, and contamination arising from intrusive thoughts, images, and impulses
Evidence: *PS,* Radomsky et al. (2014). *CES*, e.g. questionnaire studies, Badour et al. (2013), retrospective studies, Fairbrother and Rachman (2004); Ishikawa et al. (2015). *CQS*, Coughtrey et al. (2012); Zysk et al. (2018). *ThP*, e.g. contamination fears, Rachman (1994, 2006); Rachman et al. (2015); Rachman and Hodgson (1980).

Ability to demonstrate knowledge of, and recognise the key features of, (a) contact and (b) mental contamination
Evidence: *PS,* Radomsky et al. (2014). *CES*, e.g. questionnaire studies, Badour et al. (2013), retrospective studies, Fairbrother and Rachman (2004); Ishikawa et al. (2015). *AES*, e.g. induction of contamination fears in non-clinical and analogue samples, including use of the 'dirty kiss paradigm', Coughtrey et al. (2012); Elliot and Radomsky, 2009, 2012; Fairbrother et al. (2005); Herba and Rachman, (2007); Ishikawa et al. (2014); Millar et al. (2016); Rachman et al. (2012); Radomsky and Elliott, (2009); Waller and Boschen, (2015). *CQS*, Coughtrey et al. (2012). *ThP*, e.g. contamination fears, Rachman (1994, 2006); Rachman et al. (2015); Rachman and Hodgson (1980).

Ability to demonstrate knowledge of the relationship between contact and mental contamination
Evidence: *CES*, Questionnaire study on a clinical sample of people with OCD and obsessive-compulsive symptoms, Coughtrey et al. (2012); association between clinical and mental contamination symptoms, Mathes et al. (2019). *ThP*, Rachman (2006); Rachman et al. (2014).

Ability to demonstrate knowledge of psychometric measures of contamination -- e.g., washing subscale of the Obsessive Compulsive Inventory, the Mental Contamination subscale of the Vancouver Obsessive Compulsive Inventory, the Contamination Thought-Action Fusion Scale, Sensitivity to Contamination Scale, and the Morphing Fear Questionnaire
Evidence: *PS,* Foa et al. (2002); Foa et al. (1998); Melli et al. (2015); Radomsky et al. (2014); Zysk et al. (2015). *ThP*, Rachman et al. (2014).

Ability to demonstrate knowledge of the role of disgust in contamination and differences in trajectories in habituation
Evidence: *SR,* Ludvik et al. (2015). *CES*, Melli et al. (2014); Poli et al. (2019). *AES*, Deacon and Olatunji (2007); Olatuni et al. (2004); Wolitzky-Taylor et al. (2009). *ThP*, Mancusi et al., 2017

Ability to demonstrate knowledge of the role of mental imagery in contamination fears
Evidence: *CR,* Veale et al. (2015). *CES*, Coughtrey et al. (2013). *CQS*, Coughtrey et al. (2015). *ThP*, Rachman (2007).

Ability to demonstrate knowledge of the role of counterproductive behavior in contamination fears, including avoidance and repeated washing
Evidence: *AES,* Rachman et al. (2011). *ThP,* Rachman et al. (2014).

Ability to demonstrate knowledge of the role of memory biases in contamination fears
Evidence: *AES,* Radomksy et al. (2014).

Ability to demonstrate knowledge of the role of mislabelling mood states in the maintenance of contamination fears
Evidence: *ThP,* Rachman et al. (2014).

Ability to demonstrate knowledge of the role of concealment in maintaining appraisals
Evidence: *SR*, repugnant obsessions, Moulding et al. (2014). *ThP,* Newth and Rachman (2001).

Ability to demonstrate knowledge of morality, perpetrators, and betrayal in mental contamination
Evidence: *AES,* Elliott and Radomsky (2009); Rachman et al. (2012).

Ability to demonstrate knowledge of the role of self-esteem and self-identity in contamination fears
Evidence: *AES,* Ahern et al. (2015). *ThP,* Ahern and Kyrios (2016).

Ability to demonstrate knowledge of the spread of contamination fears and their decay over time
Evidence: *CES,* Rachman et al. (1976); Tolin et al. (2004). *AES,* Coughtrey et al. (2014a, 2014b). *ThP,* Riskind et al. (2012).

Ability to demonstrate knowledge of different specialty CBT approaches to the treatment of contamination fears
Evidence: *SR,* Pooniah et al. (2013). *RCT,* danger ideation reduction therapy, Jones and Menzies (1998). *CS,* Coughtrey et al. (2013). *ThP,* Rachman et al. (2014).

Specialty Competencies:
Ability to assess the current problem and its impact in detail, including asking for a specific and recent example of contamination fear
Evidence: *CS,* Coughtrey et al. (2013). *ThP,* Rachman (2006); Rachman et al. (2014).

Ability to gather information about the source(s) of contamination, in particular human sources and hypervigilance to these sources
Evidence: *CS,* Coughtrey et al. (2013). *ThP,* Rachman (2006); Rachman et al. (2014).

Ability to take a detailed history of the development of contamination, including questions about when the problem started, speed of onset, how the patient makes sense of the problem and personal vulnerability
Evidence: *CS,* Coughtrey et al. (2013). *ThP,* Rachman (2006); Rachman et al. (2014).

Ability to assess previous or current physical and psychological violations and betrayals
Evidence: *CS,* Coughtrey et al. (2013). *AES,* Elliott and Radomsky (2009); Rachman et al. (2012). *ThP,* Rachman (2006); Rachman (2010); Rachman et al. (2014).

Ability to obtain information about the perceived nature of the spread of contamination
Evidence: *CES,* Rachman et al. (1976); Tolin et al. (2004). *AES,* Coughtrey et al. (2014a); Coughtrey et al. (2014b). *ThP,* Looming vulnerability model, Riskind et al. (2012).

Ability to include assessment of mental imagery, including the presence and nature of any protective imagery
Evidence: *CR,* imagery rescripting in OCD, Veale et al. (2015). *CES,* Coughtrey et al. (2013). *CQS,* Coughtrey et al. (2015). *ThP,* Rachman (2007); Rachman et al. (2014).

Ability to provide psychoeducation about the nature and origins of contact, mental contamination, and the mislabelling of mood states
Evidence: *CS,* Coughtrey et al. (2013). *AES,* Rees et al. (2014). *ThP,* Rachman (2006); Rachman et al. (2014).

Ability to support patients to monitor and record contaminating triggers, the intensity of perceived contamination, location of perceived contamination within themselves, and subsequent behavior -- e.g., avoidance, washing, forming a protective image
Evidence: *CS,* Coughtrey et al. (2013). *ThP,* Rachman (2006); Rachman et al. (2014).

Ability to use surveys to collect personally relevant information -- e.g., to normalise fears or to gather information
Evidence: *RCT,* CBT for OCD, Whittal et al. 2010. *CS,* Coughtrey et al. (2013). *ThP,* Rachman (2006); Rachman et al. (2014).

Ability to use behavioral experiments to test beliefs about contamination, to provide the patient with direct personal evidence about maladaptive cognitions and behaviors, and to reduce maintaining behaviors
Evidence: *RCT,* CBT for OCD, Whittal et al. (2010). *CS,* Coughtrey et al. (2013). *ThP,* Rachman (2006); Rachman et al. (2014).

Ability to use ERP in conjunction with cognitive behavioral techniques to address contact contamination fears
Evidence: *AES,* Rachman et al. (2011). *ThP,* Craske et al. (2014); Rachman et al. (2014).

Ability to use cognitive behavioral techniques to change the meaning of the source of contamination, modify self-generating contamination fears by reinterpreting the significance of the feelings of mental contamination, and address the meaning of dirtiness and link this to issues of self-esteem and self-identity
Evidence: *CS,* Coughtrey et al. (2013). *ThP,* Rachman (2006); Rachman et al. (2014).

3.11 Section name: Compulsive Checking and Pathological Doubting

Overview

First, this section provides an overview of the theoretical and practical knowledge associated with the understanding and treatment of compulsive checking and pathological doubting from a cognitive-behavioral perspective. Specifically, cognitive (e.g., Rachman, 2002; Salkovskis, 1985) and behavioral (e.g., Mowrer, 1939, 1953, 1960) models explaining the development and maintenance of checking and doubting are presented, along with resources to better identify and measure key features of these symptoms. This section further highlights the role of a number of dysfunctional

beliefs (e.g., inflated responsibility) thought to be involved in the aetiology of checking and doubting (e.g., Radomsky et al. 2010). Second, specialty competencies relevant to the treatment of these symptoms are presented. These include the ability to assess compulsive checking, provide psychoeducation, and use cognitive (e.g., behavioral experiments) and behavioral (e.g., exposure and response prevention) treatment strategies to target symptoms and challenge maladaptive cognitions.

Definition of Key Terms

To properly understand this section, specific concepts should be defined and/or clarified: a) in research, *urges to check* are assessed using self-report measures, whereas *checking* is assessed by quantifying actual checking behavior; b) *inflated responsibility* is the belief that one has influence over a real or imagined negative outcome and is therefore responsible to prevent it (Clark, 2004); c) *threat overestimation* is the belief that a given negative consequence is catastrophic (i.e., harm severity) and likely to occur (i.e., harm probability; Clark, 2004); d) *beliefs about memory* refer to one's perception of their retrospective and/or prospective memory confidence, vividness, and/or detail (e.g., Rachman, 2002; van den Hout and Kindt, 2003a); e) *reassurance seeking* (i.e., checking by proxy) is the repetitive seeking of safety-related information, despite having already received the information previously (Parrish and Radomsky, 2010).

Level of Evidence

Randomized controlled trials, meta-analyses, and systematic reviews have supported the efficacy and effectiveness of exposure and response prevention (e.g., Foa et al. 2005), cognitive-behavior therapy (e.g., Abramowitz et al. 2002; Olatunji et al. 2013), and cognitive therapy (e.g., Whittal et al. 2010) for compulsive checking. Psychometric, experimental, and intervention studies have also provided evidence for cognitive models of compulsive checking and pathological doubting, by showing that maladaptive beliefs lead to and maintain urges to check and checking behavior (see Radomsky et al. 2010). However, the evidence supporting the use of inference-based therapy for checking is limited to a small-scale randomized controlled trial (O'Connor et al. 2005), and the evidence supporting behavioral strategies for reassurance seeking is limited to case studies (Halldorsson, 2015).

Recommendations for Further Research

Although exposure and response prevention has been shown to be effective and efficacious in treating compulsive checking, a number of individuals are left unwell post-treatment and/or drop out due to the difficulty of facing anxiety-provoking situations and stimuli (e.g., Foa et al. 2005). As a result, future research should emphasize 1) the development of more acceptable treatment strategies (especially cognitive interventions) and 2) the identification of other maladaptive beliefs involved in the aetiology and maintenance of checking and doubting as a way to improve treatment (e.g., Gagné and Radomsky, 2017). Importantly, research supporting the efficacy of behavioral, cognitive, and/or other related therapies for reassurance seeking is also warranted.

COMPULSIVE CHECKING AND PATHOLOGICAL DOUBTING **Specialty Knowledge:**
Ability to demonstrate knowledge of the theoretical background relevant to the development and maintenance of compulsive checking according to different theoretical models

Evidence:
OR, Gagné et al. (2018).
ThP, Mowrer (1939, 1953, 1960); Rachman (1976, 1977, 2002); Radomsky et al. (2010); Röper et al. (1973); Röper and Rachman (1976); Salkovskis (1985); Steketee (1993).

Ability to demonstrate knowledge of and define/recognize (key features of) compulsive checking

Evidence:
ThP, Rachman (2002).
TM, Bream et al. (2017); Clark (2004); Foa et al. (2012).
TrPN, Radomsky et al. (2010).

Ability to demonstrate knowledge of psychometric measures of compulsive checking

Evidence:
OR, Antony (2001).
Maudsley Obsessional Compulsive Inventory (MOCI):
PS, Emmelkamp et al. (1999).
Obsessive-Compulsive Inventory (OCI):
PS, Foa et al. (1998); Simonds et al. (2000).
Obsessive-Compulsive Inventory—Revised (OCI-R)]:
PS, Abramowitz and Deacon (2006); Foa et al. (2002); Gönner et al. (2008); Zermatten et al. (2006).
Padua Inventory (PI):
PS, Kyrios et al. (1996); Macdonald and de Silva (1999); Sanavio (1988); Sternberger and Burns (1990); van Oppen (1992); van Oppen et al. (1995); Williams et al. (2005).
Padua Inventory—Washington State University Revision (PI-WSUR):
PS, Burns et al. (1996).
Vancouver Obsessional Compulsive Inventory (VOCI):
PS, Radomsky et al. (2006); Thordarson et al. (2004).

Ability to demonstrate knowledge of the role of inflated responsibility in compulsive checking

Evidence:
PS, Obsessive Compulsive Cognitions Working Group [OCCWG] (1997, 2001, 2003, 2005).
CES, Arntz et al. (2007); Lopatka and Rachman (1995); Radomsky et al. (2001); Shafran (1997).
AES, Haring (2005); Ladouceur et al. (1997); Leonhart and Radomsky (2019); van den Hout and Kindt (2004).
ThP, Rachman (2002); Salkovskis (1985).
TrPN, Radomsky et al. (2010).

Ability to demonstrate knowledge of the role of threat overestimation (i.e., harm probability and harm severity) in compulsive checking

Evidence:
PS, OCCWG (1997, 2001, 2003, 2005).

CES, Arntz et al. (2007).
AES, Haring (2005).
ThP, Rachman (2002).
TrPN, Radomsky et al. (2010).

Ability to demonstrate knowledge of the role of memory confidence, vividness, and detail, and of negative beliefs about (retrospective and prospective) memory in compulsive checking and doubting

Evidence:
OR, Rachman and Shafran (1998).
RCS, Alcolado and Radomsky (2016).
CES, Boschen and Vuksanovic (2007); Radomsky and Alcolado (2010); Radomsky et al. (2014).
AES, Alcolado and Radomsky (2011); Coles et al. (2006); Cuttler et al. (2013); Radomsky et al. (2006); Toffolo et al. (2016); van den Hout and Kindt (2003a, 2003b).
CS, MacDonald et al. (1997); McNally and Kohlbeck (1993).
ThP, Rachman (2002).
TrPN, Radomsky et al. (2010).

Ability to demonstrate knowledge of the role of counterproductive behavior (repetition, mental checking, staring) in compulsive checking and doubting

Evidence:
CES, Boschen and Vuksanovic (2007); Radomsky et al. (2014).
AES, Coles et al. (2006); Radomsky and Alcolado (2010); Radomsky et al. (2006); Toffolo et al. (2016); van den Hout et al. (2008); van den Hout et al. (2009); van den Hout and Kindt (2003a, 2003b).
ThP, Rachman (2002).

Ability to demonstrate knowledge of the role of negative beliefs about losing control over one's thoughts and behavior in compulsive checking

Evidence:
AES, Gagné and Radomsky (2017).
PS, Radomsky and Gagné (2019).

Ability to recognize reassurance seeking and demonstrate knowledge of the links and differences between reassurance seeking and checking behavior

Evidence:
OR, Rachman and Shafran (1998).
CS, Halldorsson (2015); Parrish and Radomsky (2010); Starcevic et al.(2012).
PS, Cougle et al. (2012); Joiner and Metalsky (2001); Kobori and Salkovskis (2013); Rector et al. (2011).
AES, Neal and Radomsky (2015); Parrish and Radomsky (2006, 2011).
CQS, Kobori et al. (2012).
ThP, Rachman (2002); Rachman and Hodgson (1980); Salkovskis (1985).

Ability to demonstrate knowledge of different specialty CBT approaches (including predictors of change) to the treatment of compulsive checking
Evidence: *MA,* Abramowitz et al. (2002); Olatunji et al. (2013). *SR,* Ponniah et al. (2013). *RCT,* Foa et al. (2005); O'Connor et al. (2005); Whittal et al. (2010). *RCS,* Alcolado and Radomsky (2016). *OCT,* Radomsky et al. (2020). *CR,* O'Connor et al. (2005); O'Conno et al. (2009); Radomsky et al. (2020). *TM*, Bream et al. (2017); Clark (2004); Foa et al. (2012); Wilhelm and Steketee (2006). *TrPN,* Radomsky et al. (2010).

Specialty Competencies:
Ability to identify, formulate, and assess the current problem and its impact (including semi-structured interviews, self-report measures, specific and recent examples of checking, and a detailed history of the development of checking)
Evidence: *RCS,* Alcolado and Radomsky (2016). *ThP,* Rachman (2002). *TM,* Bream et al. (2017); Clark (2004); Foa et al. (2012); Wilhelm and Steketee (2006). *TrPN,* Radomsky et al. (2010).

Ability to provide psychoeducation on the treatment rationale and the nature and origins of compulsive checking and doubting (including the interactions with memory confidence)
Evidence: *RCS,* Alcolado and Radomsky (2016). *AES,* Rees et al. (2014). *ThP,* Rachman (2002). *TM,* Bream et al. (2017); Clark (2004); Foa et al. (2012); Rachman (2003); Wilhelm and Steketee (2006). *TrPN,* Radomsky et al. (2010).

Ability to support patients to monitor and record checking behavior and urges to check in treatment
Evidence: *TM,* Bream et al. (2017); Clark (2004); Foa et al. (2012); Wilhelm and Steketee (2006). *TrPN,* Radomsky et al. (2010).

Ability to use surveys to collect personally relevant information (e.g., information on others' checking habits)
Evidence: *TM,* Bream, Challacombe et al. (2017); Clark (2004); Rachman (2003); Rachman et al. (2014); Wilhelm and Steketee (2006).

Ability to use behavioral experiments to target a) beliefs about responsibility, b) harm probability, c) harm severity, d) negative beliefs about memory, e) the impact of repetition on doubting and memory confidence, vividness, and detail, and f) beliefs about losing control
Evidence: *OR,* Gagné et al. (2018). *RCS,* Alcolado and Radomsky (2016). *TM,* Bennett-Levy et al. (2004); Bream et al. (2017); Clark (2004); Rachman (2003); Wilhelm and Steketee (2006). *TrPN,* Radomsky et al. (2010).

Ability to use cognitive-behavioral techniques to challenge the meaning attributed to doubt
Evidence: *ThP,* Rachman (1997, 1998). *TM,* Rachman (2003).

Ability to assess reassurance seeking and apply strategies that can reduce it
Evidence: *PS,* Cougle et al. (2012); Joiner and Metalsky (2001); Kobori and Salkovskis (2013); Rector et al. (2011). *AES,* Neal and Radomsky (2019a, 2019b). *TM,* Bream et al. (2017); Clark (2004); Foa et al. (2012).

3.12 Section Name: Incompleteness/Not Just Right Experiences

Overview

There is increased interest in the significance of fundamental affective experiences that underlie and motivate the diverse overt symptoms seen in OCD. Prevailing conceptualizations of OCD (including for psychological treatment) have focused on an anxious/harm-avoidant profile. However recent years have seen recognition of "incompleteness" as another core affective feature. Like harm-avoidance, incompleteness has been proposed to cut across overt OCD symptom expressions/dimensions but to be associated with some (e.g., symmetry and ordering) more than others. This form of OCD presents many considerations and challenges for treatment. Existing evidence indicates that although symptoms and features most associated with incompleteness are also often those identified as being the least responsive to specialty cognitive-behavioral therapy (CBT), CBT with an emphasis on ERP can be adapted effectively. Systematic clinical research on incompleteness in OCD is needed.

Definition of Key Terms

Incompleteness: A distressing sense of dissatisfaction or discomfort with one's current state, connected with the perception that actions or intentions have been incompletely achieved (Rasmussen and Eisen, 1992; Summerfeldt, 2004) – widely known as a "not just right experience"

(NJRE; Coles et al. 2003). This is often experienced as a sensory-affective disturbance. Incompleteness is distributed throughout the population, with higher levels associated with obsessive-compulsive behaviors and symptoms. It seems to represent the extreme end of a continuum of obsessive-compulsive perfectionistic personality traits and have parallels in such obsessive-compulsive "spectrum" conditions as tic disorders and perhaps some aspects of body dysmorphic disorder.

Levels of Evidence

Evidence of the phenomenology and correlates of incompleteness comes from many theoretical papers, case studies and series, and research with clinical and nonclinical samples using correlational and less commonly quasi-experimental designs. To date, only a small body of research has directly examined treatment implications, such as for CBT design, delivery, and outcomes. Published evidence derives from a few case studies and discussion papers (e.g., Summerfeldt, 2004, 2007; Schubert et al. 2016) and two pilot open trials of ERP for incompleteness/not just right experiences (Coles and Ravid, 2016; Mathes et al. 2019), and a meta-analysis using published and unpublished data from controlled and uncontrolled treatment studies (Schwartz, 2018). Indirect evidence also comes from clinical research on the OCD symptoms most associated with incompleteness -- symmetry and ordering -- although they are also under-represented in treatment studies.

Recommendations for Further Research

Further experimental and clinical evidence for causal factors in incompleteness is needed, in order to inform models of treatment. For example, traditional cognitive-appraisal etiological models of OCD may not apply, as in incompleteness the core sensory-affective disturbance may precede, rather than result from, faulty appraisals. Key cognitive factors may rather include problematic appraisals of incompleteness/not just right experiences (e.g., as intolerable or escalating) as well as post-facto beliefs, with both mediating associated distress and symptom severity. This has direct implications for CBT approaches. With regard to treatment, systematic research at all levels is required. To date, incompleteness has not been incorporated into any controlled trials of ERP or CBT for OCD. Several ERP adaptations noted in this section are consistent with treatment principles based on inhibitory learning theory, warranting further research. Direct and indirect evidence suggests that incompleteness-related clinical features are associated with less CBT entry, adherence, and completion. Research is therefore indicated on therapy components which enhance treatment readiness and acceptability for these individuals. Given the unique challenges noted in this section, augmentation with cognitive therapy, data on therapy components and process variables, and optimization of long-term treatment benefits will also be of particular interest. Further research is additionally needed on the shared versus distinct phenomenology (mutually as well as with incompleteness) and effective treatment of distressing sensory phenomena in OCD such as misophonia (sensitivity to sounds), "need for energy release", and sensory intolerance, hypersensitivity, or over-responsivity (e.g., Shavitt et al. 2014; Grimaldi and Stern, 2017; Eng et al., 2020; Houghton et al. 2020).

INCOMPLETENESS/NOT JUST RIGHT EXPERIENCES **Specialty Knowledge:**
Ability to demonstrate knowledge of phenomenology of incompleteness
Evidence: *SR*, da Silva Prado et al. (2008). *OR*, Rasmussen and Eisen (1992). *CSS*, Belloch et al. (2016); Coles et al. (2003); Ecker and Gönner (2008); Ferrão et al. (2012); Ghisi et al. (2010); Miguel et al. (2000); Sibrava et al. (2016). *CR*, Summerfeldt (2004, 2007). *AES*, Summers et al. (2014). *ThP*, Pietrefesa and Coles (2008). *TrPN*, Hood and Antony (2016).

Ability to demonstrate knowledge of extant models of the role of incompleteness in OCD
Evidence: *OR*, Rasmussen and Eisen (1992). *CSS,* Taylor et al. (2014). *PS,* Summerfeldt et al. (2014). *CR,* Summerfeldt (2004, 2007). *AES*, Pietrefesa and Coles (2009). *ThP,* Pietrefesa and Coles (2008).

Ability to demonstrate knowledge of manifest OCD symptom correlates of incompleteness
Evidence: *OR*, Rasmussen and Eisen (1992). *OCT*, Coles and Ravid (2016). *CSS,* Belloch et al. (2016); Coles et al. (2003); Ecker and Gönner (2008); Sibrava et al. (2016); Taylor, McKay et al. (2014). *CR*, Summerfeldt (2004, 2007).

Ability to recognize differential diagnoses and common comorbidities and demonstrate knowledge that they may complicate/impede treatment
Evidence: *OR,* Fineberg et al. (2014). *CC,* Sica et al. (2015). *CSS,* Coles et al. (2008); Ecker et al. (2014a, 2014b); Leckman et al. (1994); Sibrava et al. (2016); Taylor et al. (2014).

Ability to demonstrate knowledge of clinical features of incompleteness-related OCD that may complicate/impede treatment

Evidence:
SR, da Silva Prado et al. (2008); Prada et al. (2008).
OR, Coles and Pietrefesa (2007); Rasmussen and Eisen (1992).
CS, Mancebo et al. (2011).
CC, Rosario-Campos et al. (2001).
CSS, Belloch et al. (2016); Kichuk et al. (2013); Sibrava et al. (2016).
CR, Summerfeldt (2004).
AES, Radomsky and Rachman (2004).
CQS, Rachman (1974).

Ability to recognize incompleteness-related clinical features and demonstrate knowledge that they are associated with lower rates of CBT entry, adherence, and completion

Evidence:
SR, Ball et al. (1996); McKay et al. (2015).
RCT, Mataix-Cols et al. (2002).
CR, Tallis (1996).
CES, Abramowitz et al. (2003).
ThP, Pietrefesa and Coles (2008).

Ability to demonstrate knowledge of empirically supported methods of incompleteness assessment

Evidence:
Not-Just-Right-Experiences Questionnaire (Revised) (NJRE-Q-R)
CSS, Coles et al. (2003); Ghisi et al. (2010).
AES; Coles et al. (2005).

Obsessive-Compulsive Core Dimensions Questionnaire (OC-CDQ) and Interview (OC-CDI)
PS, Pietrefesa and Coles (2008); Summerfeldt et al. (2014); Taylor et al. (2014)
AES, Pietrefesa and Coles (2009).

Brown Incompleteness Scale (BINCS)
PS, Boisseau et al. (2018).

Picture-Based Measure of NJREs (PIC-NR10)
PS, Davine et al. (2018).

Yale-Brown Obsessive–Compulsive Scale (second edition) (Y-BOCS-II) Symptom Checklist
PS, Storch et al. (2010); Wu et al. (2016).

Ability to demonstrate knowledge that existing evidence indicates ERP as first line treatment

Evidence:
MA, Schwartz (2018).
RCT, Mataix-Cols et al. (2002).
OCT, Coles and Ravid (2016); Mathes et al. (2019).
CR, Summerfeldt (2004, 2007); Tallis (1996).
ThP, Pietrefesa and Coles (2008).
TM, Sookman (2016).

TrPN, Schubert et al. (2016).

Ability to demonstrate knowledge of evidence for, and limitations of, cognitive components of the standard cognitive-behavioral model of OCD with regard to incompleteness
Evidence: *RCT*, Su et al. (2016). *CSS,* Belloch et al. (2016); Bragdon and Coles (2017); Chik et al. (2010); Taylor et al. (2006). *CR,* Summerfeldt (2004, 2007); Tallis (1996). *ThP,* Cougle and Lee (2014). *TrPN,* Schubert et al. (2016).

Specialty Competencies:
Ability to identify, formulate, and assess the current problem and integrate different sources of information regarding incompleteness-related symptoms, including clinical interviews, behavioral observations, and questionnaires
CSS, Coles et al. (2003). *PS*, Boisseau et al. (2018); Storch et al. (2010); Summerfeldt et al. (2014). CR, Summerfeldt (2004, 2007). TrPN, Hood and Antony (2016); Schubert et al. (2016).

Ability to formulate maintenance of incompleteness-related emotion and counter-productive strategies (compulsions, compulsions, avoidance) from a cognitive-behavioral perspective
Evidence: *MA*, Schwartz (2018) *OCT,* Coles and Ravid (2016); Mathes et al. (2019). *CR*, Summerfeldt (2004, 2007). *TM,* Sookman (2016). *TrPN,* Hood and Antony (2016); Schubert et al. (2016); Sookman and Steketee (2007).

Ability to recognize the breadth and pervasiveness of incompleteness-related behaviors and their impact on psychosocial functioning
Evidence: *CSS,* Sibrava et al. (2016). *CR*, Summerfeldt (2004, 2007).

Ability to plan treatment based on the formulation, with emphasis upon ERP
Evidence: *MA,* Schwartz (2018). *OCT,* Coles and Ravid (2016); Mathes et al. (2019). *CR,* Summerfeldt (2004, 2007). *TM,* Schwartz (1996); Sookman (2016). *TrPN,* Sookman and Steketee (2007).

Ability to enable self-monitoring in order to identify and generate collaboratively a detailed list of internal and external cues that provoke incompleteness, and to address any reluctance to discuss these
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *TrPN,* Hood and Antony (2016).

Ability to extend "SUDS" concept to incompleteness-relevant affect (e.g., not just right experiences, tension, discomfort)
Evidence: *MA,* Schwartz (2018). *OCT*, Coles and Ravid (2016); Mathes et al. (2019). *CR*, Summerfeldt (2004, 2007). *TM,* Sookman (2016). *TrPN,* Schubert et al. (2016).

Ability to identify collaboratively all behavioral and cognitive compulsions and avoidance used to reduce incompleteness-related discomfort
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *TrPN,* Schubert et al. (2016).

Ability to collate information from assessment to determine the nature and context for in vivo exposures and to design (potentially multiple) variable "hierarchies"
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *ThP,* Craske et al, 2014. *TM,* Sookman (2016). *TrPN,* Hood and Antony (2016).

Ability to demonstrate competency in general elements of engaging the patient with CBT for OCD, given likely incompleteness-related treatment ambivalence and lower treatment adherence and/or response
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *TrPN,* Schubert et al. (2016).

Ability to provide a general explanation of the phenomenology, etiology and maintenance of incompleteness symptoms, to apply this in a case formulation, and to explain the rationale for CBT
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *TM,* Sookman (2016). *TrPN,* Schubert et al. (2016).

Ability to appraise motivation to engage in ERP, and to discuss this using standardized and customized methods both before and during CBT
Evidence: *RCS*, Meyer et al. (2010). *OCT*, Simpson et al. (2008). *CR,* Timpani et al. (2016).

Ability to work with the patient to develop multiple or multi-themed graded and/or variable exposures
Evidence: *OCT*, Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *ThP* Craske et al. (2014). *TrPN,* Hood and Antony (2016).

Ability to revise the variable "hierarchy" creatively and collaboratively in relation to the patient's response and as new information about incompleteness discomfort arises during treatment
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *TM,* Sookman (2016). *ThP* Craske et al. (2014).

Ability to gauge and adjust the nature and duration of exposures, given possible value of "lifestyle change" approach to ERP for incompleteness
Evidence: *CR*, Summerfeldt (2004, 2007). *TM,* Sookman (2016). *TrPN*, Schubert et al. (2016).

Ability to build a plan for response prevention, preferably by eliminating compulsions, and modifying this as clinically indicated; for incompleteness ERP may target duration as well as inflexible forms and sequences of compulsive behavior
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007). *TrPN,* Hood and Antony (2016).

Ability to adapt SUDS plotting strategies creatively and collaboratively, in order to monitor progress
Evidence: *OCT,* Coles and Ravid (2016). *CR*, Summerfeldt (2004, 2007).
Ability to detect and manage complications which arise during ERP, such as shifting of compulsionizing form and/or foci (including to exposure activities) or shifting of compulsionizing to avoidance
Evidence: *CR,* Summerfeldt (2004, 2007).

Ability to demonstrate competency in all elements of relapse prevention for OCD, given typical duration, pervasiveness, and entrenchment of incompleteness and related behaviors
Evidence: *CSS,* Sibrava et al. (2016). *CR*, Summerfeldt (2004, 2007).

Ability to tailor and utilize cognitive therapy as augment to ERP for incompleteness, with a focus on reappraisal of sensory-emotional experience/not just right experiences
Evidence: *MA,* Schwartz (2018). *TM,* Sookman (2016). *TrPN,* Sookman and Steketee (2007).

Ability to incorporate mindfulness-based therapy methods, both to reinforce cognitive therapy, and boost acceptability of, and aid relapse prevention post, ERP
Evidence: *SR*, Hale et al. (2013). *CQS,* Sguazzin et al. (2017). *TM,* Schwartz (1996). *TrPN,* Twohig et al. (2015).

3.13 Section Name: Overvalued Ideation

Overview

Overvalued ideation refers to a system of beliefs that, although dysfunctional, are held strongly and have a strong affective component when contradictory information is presented (Neziroglu et al. 2004). Veale, (2002) argues that over-valued ideas are derived from idealised values, which have developed into such an over-riding importance, that they totally define the 'self' or identity of the individual. Idealised values are also characterised by the rigidity with which they are held. Such patients are unable to adapt to different circumstances and ignore the consequences of acting on their value.

The term overvalued ideation is roughly equivalent to the terms "poor insight" and "absent insight (delusional beliefs)," which are often used in the OCD literature, although the insight terms do not as strongly emphasize the affective component of the belief. Overvalued ideations tend to be fixed but can be modified if challenged, especially by pragmatism (for example the conflict in their values) rather than empiricism or logic. The presence of overvalued ideation in patients with OCD has been theoretically linked to poorer treatment outcome. OCD sufferers with high overvalued ideation may seem to have delusional beliefs, but these present differently compared with schizophrenia, primarily in that the positive and negative symptoms of psychotic illness are not present. Some OCD patients lack insight into their irrationality (Lelliott et al. 1988; Basoglu et al. 1998), however, unlike schizophrenia OCD-related beliefs are only rarely held with complete conviction, tend to have reduced variation in strength over time, and are not associated with other psychotic symptoms (Kozak and Foa, 1994; Eisen et al. 2004; Phillips et al. 2012). The affect activation when challenging main beliefs may narrow and restrict attention, making it difficult for the patient to shift attentional sets. This leads to an overall impairment in judgement which may ultimately interfere with treatment outcome (Neziroglu et al. 1999).

Levels of Evidence

The levels of evidence provided in this section are from a variety of sources including systematic reviews and meta-analyses, clinical trials, treatment outcome studies, exploratory studies; theoretical papers and books; as well as expert opinion.

Recommendations for Further Research

Future research should test the concept stability of overvalued ideation and investigate impacts on dropout rate and treatment compliance. Additionally, techniques for self-identification and measurement of the beliefs and idealized valued are needed. Further research on the development of OVI in pediatric OCD could also pave the way for forthcoming treatment advancements.

OVERVALUED IDEATION **Specialty Knowledge:**
Ability to demonstrate knowledge of phenomenology of overvalued ideas and to define and recognize overvalued ideation (poor or absent insight)
Evidence: *MA,* Neziroglu (2008). *CSS,* Eisen et al. (2004); Phillips et al. (2012). *ThP*, Yaryura-Tobias (2004); Veale (2002). *TrPN,* McKay et al. (2015).

Ability to demonstrate knowledge of the theoretical background of the development of overvalued ideas
Evidence: *MA,* McKenna (1994). *RCS,* Neziroglu et al. (2001); Wernicke (1990). *ThP*, Jaspers (1913); Yaryura-Tobias (2004); Veale (2002). *TrPN,* Kozak and Foa (1994).

Ability to demonstrate knowledge of the different types of OCD symptom correlates of overvalued ideation
Evidence: *CSS,* Eisen et al. (2004); Phillips et al. (2012). *ThP,* Yaryura-Tobias (2004). *TrPN,* Kozak and Foa (1994).

Ability to demonstrate knowledge of overvalued ideation assessment methods.
Evidence: *RCT,* Goodman et al. (1989). *RCS*, Neziroglu et al. (1999). *PS*, Eisen et al. (1998). *CR*, Neziroglu and Khemlani (2003).

Ability to demonstrate knowledge of overvalued ideation-related clinical features that are associated with poorer adherence and CBT treatment outcome
Evidence: *RCS,* Neziroglu et al. (2001). *CQS*, Koazak and Foa (1994).

Ability to demonstrate knowledge of different specialty CBT approaches to the treatment of overvalued ideation in OCD and what approaches yield the best outcome
Evidence: *RCS,* Main-Wegielnik (2010); Twohig et al. (2006). *CQS*, Neziroglu et al. (2010); Pinto et al. (2007).

Ability to demonstrate knowledge of appropriate and helpful use of "naturalistic" CBT (i.e., outside office in feared situations) for OCD associated with overvalued ideation
Evidence: *RCS,* McKay et al. (1996).

Ability to demonstrate knowledge of when intensive outpatient or residential treatment is needed for OCD associated with overvalued ideation
Evidence: *SR and MA,* Veale et al. (2016). *CQS,* Wilson et al. (2014).

Ability to demonstrate knowledge of how overvalued ideation may lead to noncompliance, excessive reassurance seeking, or avoidance
Evidence: *TM,* Neziroglu et al. (2009).

Ability to demonstrate knowledge of clinical features of overvalued ideation-related OCD that may complicate/impede treatment
Evidence: *RCS,* Neziroglu et al. (1999).

Ability to demonstrate knowledge of criteria for assessment of degree of change in overvalued ideation
Evidence: *PS,* McKay et al. (1999), Maitaix-Cols et al. (2016). *TM,* Sookman and Steketee, (2010).

Specialty Competencies:
Ability to help the patient to identify overvalued ideation and the internal and external cues that provoke these, and to enable the patient to overcome reluctance to disclose and discuss these (e.g., due to shame)
Evidence: *RCS,* Neziroglu et al. (2001). *TrPN,* Neziroglu, and Stevens (2002).

Ability to assess symptoms of overvalued ideation using different standardized measures
Evidence: *RCT,* Goodman et al. (1989). *PS,* Eisen et al. (1998); Neziroglu et al. (1999).

Ability to create and maintain a positive therapeutic relationship as the patient with overvalued ideation may feel that his/her cognitions and feelings are being challenged, leading to reluctance to engage in treatment

Evidence: *RCS,* Neziroglu et al. (1999); Vogel et al. (2006).

Ability to provide an explanation of the phenomenology, etiology and maintenance of overvalued ideation symptoms, to apply this in a case formulation, and to explain the rationale for specific CBT interventions to address these ideas and related symptoms to the patient
Evidence: *RCS,* Neziroglu et al. (2001). *ThP*, Veale (2002).

Ability to help the patient to identify all behavioral and cognitive compulsions and avoidance used to reduce overvalued ideation- related discomfort
Evidence: *RCS,* Neziroglu et al. (2001). *ThP*, Yaryura-Tobias (2004). *TM*, Neziroglu et al. (2013). *TrPN*, McKay et al. (2015).

Ability to develop a case conceptualization and treatment plan for overvalued ideation that is progressive and individualized with the patient, and to collaborate on the plan with other clinicians
Evidence: *SR and MA,* Veale et al. (2016*)* *RCS,* Neziroglu et al. (2001). *TM,* Neziroglu et al. (2013)

Ability to identify when to make changes to the treatment plan and rationale for overvalued ideation
Evidence: *SR and MA,* Veale et al. (2016). *TM,* Neziroglu et al. (2013). *TrPN,* Neziroglu et al. (2006).

Ability to develop behavioral experiments that target specific overvalued ideas to optimize disconfirmatory learning both in session and as homework
Evidence: *RCS,* Neziroglu et al. (1999); Neziroglu et al. (2001). *TM,* Neziroglu et al. (2013); Veale (2007)

Ability to identify how cognitive therapy can be utilized to reduce overvalued ideation
Evidence: *RCS,* Neziroglu et al. (2001). *CQS,* Wilson et al. (2014). *TM*, Neziroglu et al. (2013).

Ability to use ERP to address overvalued ideation including "overpractice"
Evidence: *RCS,* Neziroglu et al. (2001); Neziroglu et al. (1999). *CQS,* Wilson et al. (2014). *TrPN,* McKay et al. (2015).

Ability to teach, model and assist the patient in adaptive coping with high overvalued ideation situations within and between sessions
Evidence: *RCS,* Neziroglu et al. (1999). *CQS,* Röper et al. (1975). *TM,* Didonna (2009); Hayes (2016); Troth et al. (2014)

Ability to engage in multi-disciplinary collaboration (specialty CBT and psycho-pharmacotherapy) for overvalued ideation
Evidence: *RCS,* Neziroglu et al. (2001). *CQS,* Neziroglu et al. (2004). *TrPN,* McKay et al. (2015).

Ability to utilize motivational interviewing in conjunction with cognitive therapy for some cases of overvalued ideation
Evidence: *RCS,* Neziroglu et al. (2001). *OCT,* Simpson and Zuckoff (2011). *CQS,* Pinto et al. (2007); Wilson et al. (2014). *TM,* Corbett (2016).

Ability to assess family interactions, provide family intervention including psychoeducation and coping strategies, and to identify when family therapy is indicated (see family-based interventions in this paper)
Evidence: *SR and MA,* Veale et al. (2016). *RCS,* Grunes et al. (2001). *CQS,* Gomes et al. (2014).

Ability to assess on an ongoing basis treatment outcome using overvalued ideation measurements as well as measurements of OCD, depression, and anxiety
Evidence: *PS,* Eisen et al. (1998); Neziroglu et al. (1999).

Ability to set up a relapse prevention program for overvalued ideation after treatment termination
Evidence: *SR and MA,* Veale et al. (2016).

RCS, Neziroglu et al. (1999).
PS, McKay et al. (1996).
CQS, Wilson et al. (2014).

3.14 Section Name: Management of Treatment-Interfering Behavior

Overview
During the implementation of specialized treatment for OCD, it is common for patients to engage in one form or another of treatment-interfering behavior. Although the portion of OCD treatment failures due specifically to treatment-interfering behavior is currently unknown, existing research indicates that it represents a major obstacle to successful OCD treatment. Evidence suggests that 25-30% of individuals with OCD who have appropriate access to CBT are likely to refuse therapy, and a comparable percentage of individuals drop out of therapy prematurely (Foa et al. 1983; Kozak et al. 2000). For those who complete CBT, nonadherence is a significant predictor of poor outcome (Simpson et al. 2012). Some treatment-interfering behavior can either be prevented or managed adequately by the clinician without significantly disrupting treatment of the OCD. However, in the event of severe and pervasive treatment-interfering behavior, specific attention devoted to modifying this behavior may be necessary before OCD treatment can be conducted effectively. This section outlines the knowledge and competencies necessary to address treatment-interfering behavior to facilitate successful OCD treatment outcomes. In assessing reasons for treatment resistance both patient and intervention factors should be considered, including insufficient or inadequate application of evidence-based disorder specific interventions for OCD.

Description of Key Terms
Treatment-Interfering Behavior: Any behavior incompatible with effective participation in specialized treatment for OCD. Common examples include refusing treatment, failing to complete homework assignments, missing appointments, reporting inaccurate information, engaging in aggressive or argumentative behavior, dropping out of treatment prematurely, and repeatedly switching the focus of therapy. The term is often used to describe behavior that emerges during the context of psychotherapy. However, treatment-interfering behavior can also occur during the administration of other treatments such as pharmacotherapy.

Therapy-Interfering Behavior: Largely synonymous with the term treatment-interfering behavior, but typically used solely in reference to behavior that occurs within the context of psychotherapy.

Level of Evidence
Treatment ambivalence and resistance, terms typically thought to be associated with treatment-interfering behavior, have been discussed extensively in the psychotherapy literature. However, these concepts are sometimes linked to psychodynamic or other theoretical models which may be of limited use to practitioners adhering to the evidence-based cognitive and behavioral approaches for OCD. In contrast, the treatment-interfering behavior concept refers to observable behavior, is defined largely by the behavior's disruptive impact on treatment, and is not tied to a specific theoretical model. Because of these features, this concept can be used by clinicians from various theoretical orientations and is particularly compatible with cognitive and behavioral approaches.

Relatively little controlled outcome research has been conducted on interventions for treatment-interfering behavior in individuals with OCD. With few exceptions, the relevant literature consists largely of theoretical papers, clinical recommendations, case reports, and uncontrolled outcome studies. Some of the literature focuses on prevention or early intervention (e.g., Maltby and Tolin, 2003; Simpson et al. 2008), while other reports describe interventions designed to address treatment-interfering behavior that emerges during the course of therapy (e.g., Sookman and Pinard, 1999; VanDyke and Pollard, 2005; Sookman and Pinard, 2007; Sookman, 2016).

Recommendations for Further Research

Additional research designed to elucidate the prevalence and impact of treatment-interfering behavior in individuals with OCD is clearly needed. Future efforts should include refinements in the models that guide clinicians in developing interventions to address various factors that potentially influence treatment-interfering behavior. Finally, controlled outcome studies will need to examine the efficacy and effectiveness of those interventions.

MANAGEMENT OF TREATMENT-INTERFERING BEHAVIOR **Specialty Knowledge:**
Ability to demonstrate knowledge of the role of motivation and readiness for change in determining treatment outcome
Evidence: *CC*, Araujo et al. (1996); de Haan et al. (1997); Keijsers et al. (1994); Monaghan et al. (2015); Pinto et al. (2007). *ThP*, Norcross et al. (2011).

Ability to demonstrate knowledge of strategies that can be implemented early in therapy to help prevent/discourage treatment-interfering behavior (e.g., policies regarding missed sessions, late arrivals, emergency calls, requests for a change of therapist)
Evidence: *RCS*, Swensen and Pekarik (1988). *CQS*, Molfenter (2013). *TM*, Allen (1997). *EO*, Ben-Porath (2014); Welch et al. (2010).

Ability to demonstrate knowledge of the factors a therapist should consider when determining if treatment ineffectiveness is due to inadequate OCD treatment or treatment-interfering behavior
Evidence: *SR*, Neziroglu and Mancusi (2014). *RCT*, Vandyke and Pollard (2005).

Ability to demonstrate knowledge of the various treatment-interfering behaviors that commonly emerge when treating OCD
Evidence: *SR*, Pollard (2007).

CQS, Davis et al. (2020).
TM, Chapman and Rosenthal (2016).

Ability to demonstrate knowledge of the negative effects of continuing to administer CBT for OCD without sufficiently addressing treatment-interfering behavior

Evidence:
SR, Pollard (2007).
CC, Foa et al. (1983); Simpson et al. (2012).
CQS, Davis et al. (2020).
ThP, Sookman and Pinard (2007); Sookman (2016).

Ability to describe at least one theoretical model of treatment-interfering behavior that includes one or more factors (e.g., inadequate motivation, skill deficits, treatment-incompatible beliefs, family accommodation) proposed to contribute to treatment-interfering behavior

Evidence:
SR, Pollard (2007); Sookman and Steketee (2007).
RCS, Simpson et al. (2010).
TM, Allen (1997).
EO, Welch et al. (2010).

Ability to demonstrate knowledge of criteria for selecting interventions that can be used to address various factors that influence treatment-interfering behavior

Evidence:
SR, Sookman and Steketee (2007, 2010).
CR, Simpson and Zuckoff (2011); VanDyke and Pollard (2005).
CES, Twohig et al. (2006).

Specialty Competencies

Ability to identify treatment-interfering behavior in individuals with OCD

Evidence:
SR, Pollard (2007).
TM, Chapman and Rosenthal (2016).

Ability to communicate and implement interventions designed to help prevent or manage treatment-interfering behavior

Evidence:
CES, Klugar and Karrass (1983).
CQS, Molfenter (2013).
TM, Allen (1997); Chapman and Rosenthal (2016).
EO, Ben-Porath (2014).

Ability to manage treatment-interfering behavior in a non-judgmental, problem-solving manner

Evidence: *SR*, Pollard (2007). *TM*, Allen (1997); Chapman and Rosenthal (2016). *EO*, Abramowitz et al. (2003).

Ability to determine the conditions under which it is advantageous to discontinue specialty CBT for OCD symptoms and focus treatment primarily on modification of treatment-interfering behavior
Evidence: *SR*, Pollard (2007). *ThP*, Sookman and Pinard (2007).

Ability to help individuals with OCD to identify and acknowledge their treatment-interfering behavior and understand its negative impact on their treatment
Evidence: *SR*, Pollard, (2007). *TM*, Allen (1997); Chapman and Rosenthal (2016).

Ability to shift, when indicated, the primary focus of treatment from OCD symptoms to treatment-interfering behavior
Evidence: *SR,* Pollard (2007). *RCS*, Simpson et al. (2010). *TM*, Chapman and Rosenthal (2016).

Ability to educate individuals with OCD about the factors that may be contributing to their treatment-interfering behavior
Evidence: *SR*, Pollard (2007); Sookman and Steketee (2007, 2010). *RCS*, Simpson et al. (2010).

Ability to develop, administer, and assess the efficacy of cognitive interventions when treatment-incompatible beliefs contribute to treatment-interfering behavior
Evidence: *SR*, Sookman and Steetee (2007, 2010). *CR*, Krochmalik et al. (2001). *ThP*, Veale (2007). *EO*, Ellis (1985); Leahy (2001).

Ability to develop, administer, and assess the efficacy of strategies designed to enhance motivation (e.g., motivational interviewing, values clarification) when motivational deficits contribute to treatment-interfering behavior
Evidence: *SR*, Tolin and Maltby (2008). *OCT*, Simpson and Zuckoff (2008). *CC*, Simpson et al. (2012).

CES, Maltby and Tolin (2005); Twohig et al. (2006).

Ability to develop, administer, and assess the efficacy of contingency management when contingencies contribute to treatment-interfering behavior
Evidence: *OCT*, Worden et al. (2016). *CR*, Bensen et al. (2016). *EO,* Welch et al. (2010).

Ability to develop, administer, and assess the efficacy of skills training (e.g., time management, emotion regulation) when a skill deficit contributes to treatment-interfering behavior
Evidence: *RCT*, Neacsiu et al. (2014). *CR*, McKay and Neziroglu (1996). *AES*, Hafner et al. (2014). *EO*, Welch et al. (2010).

Ability to develop, administer, and assess the efficacy of family-focused interventions when family accommodation or other family factors contribute to treatment-interfering behavior
Evidence: *SR*, Lebowitz et al. (2014). *RCT*, Gomes et al. (2016); Vandyke et al. (2015); Thompson-Hollands et al. (2015). *CR*, Lebowitz (2012).

Ability to assess when treatment-interfering behavior has been sufficiently modified to warrant resuming OCD specialty treatment
Evidence: *CR*, Sookman and Pinard (1999); VanDyke and Pollard (2005). *EO*, Sookman and Steketee (2010).

3.15 Section name: Cultural Knowledge and Competencies

Overview

This section is intended to review the basic competencies recommended to work effectively with patients across cultural differences. This includes providing treatment to individuals who are of a different race or ethnicity than the therapist. These guidelines emanate from a primarily Western, Eurocentric perspective -- that is, the theoretical framework, explanatory models, and research procedures undertaken to gain the knowledge provided follow from this frame of reference. It is important to understand that other cultures may have different standards for cleanliness and/or explanatory models for OCD-related behaviors and may not completely accept a CBT conceptualization for difficulties.

Patients may be members of communities that are marginalized and stigmatized due to race or ethnicity. This means they experience discrimination, reduced opportunities, and reduced access to a society's resources, including medical care. This may pose additional difficulties that need to be addressed in treatment. Such persons may need more time to develop trust and rapport with a therapist and may have additional fears about being stereotyped due to their unwanted OCD thoughts and behaviors.

Many individuals utilize traditional healers to address mental health symptoms, and usually this includes a spicompulsion or religious component. It is not uncommon for patients with OCD to enlist priests, rabbis, and other religious leaders for help. If the therapist believes that religious beliefs are causing or worsening the OCD, the therapist may incorrectly try to control or suppress the person's beliefs to facilitate treatment. This will undermine trust and empathy, leading to conflict and drop out. Therefore, it is recommended that therapists work respectfully within the confines of the patient's religious rules and traditions, which will ultimately facilitate treatment adherence. A patient's religious values can be recruited into the service of treatment, as often the OCD has interfered with carrying out proper religious duties (e.g., prayer, attendance at services, normal compulsions) rather than improving religious life.

Other than mainstream religious practices, there are additional alternative healing practices that are connected to mental health, as many ethnic groups have introduced their approaches to health and wellbeing into the Western culture through immigration and globalization. Often referred to as of complementary and alternative medicine, this may include Ayurveda, yoga, herbal medicine, acupuncture, Voodoo, astrology, Santeria, and new age therapies. Clinicians should be prepared to discuss the role of traditional medicine and complementary and alternative medicine in the patient's treatment. It is important to show respect for these systems and acknowledge that indigenous, cultural, and traditional healing practices are time-honored methods that many people have historically used to alleviate both physical and psychological problems for generations. Given a conflict between a therapist and a traditional healer, it is helpful to collaborate with the healer if possible. Consultation with professionals familiar with the specific culture is indicated should ethical dilemmas arise, for example, if there is reason to believe a patient may be harmed by a practice that has no scientific evidence.

Description of Key Terms

Explanatory Models: Individuals and groups can have vastly different notions about the causes for health and disease. Explanatory models are beliefs about an episode of sickness and its treatment that are employed by those engaged in the clinical process.

Traditional Healers: Traditional healers, including religious healers, folk healers, and shamans, promote wellness through a variety of techniques, including prayer, spicompulsion ceremony, plant medicines, energetic therapies, and physical/hands on techniques. Ideally, traditional healers recognize but do not compete with Western medical practice. Use of traditional healers is widespread globally, and the World Health Organization supports the practice of traditional medicine to complement modern medicine.

Complementary and Alternative Medicine: These are alternative therapies that reside outside traditional medical science and may be based on theories that contradict science or have

supernatural or spicompulsion explanations for their effect. Traditional practices become alternative when used outside their original settings and without established scientific explanation and evidence. They are complementary when used alongside established medical therapies.

Racialization: Racialization is the process of ascribing racial or ethnic identities to a group that did not originally identify itself as such. Racialization is typically imposed by a dominant group and ascribes an identity for the purpose of continued domination. The racialized group often gradually identifies with and may even embrace the ascribed identity and thus it can become self-ascribed.
Mental Health Literacy: Mental health literacy is the ability to recognize specific disorders, knowing how to acquire mental health information, understanding risk factors and causes, knowing types of help available, and attitudes that facilitate recognition of disorders and appropriate help-seeking.

Level of Evidence

There is ample evidence from both the larger mental health literature and the OCD literature specifically that the competencies described herein are important for understanding cultural issues and treatment outcomes. A few findings presented here are based on the larger mental health literature, whereas less work has been done specifically on OCD and culture. Relevant research conducted in other cultures that is not available in English is not represented here.

Recommendations for Further Research

More research is needed to understand symptoms differences, cultural attitudes, and treatment approaches in non-White and non-Western populations.

CULTURAL KNOWLEDGE AND COMPETENCIES
Specialty Knowledge:
Ability to demonstrate knowledge of clinician's own biases and gaps in cultural knowledge and how this could potentially impact treatment
Evidence: *TG*, Miller et al. (2015). *CSS,* Williams et al. (2015). *ThP,* Sue et al. (2007).

Ability to demonstrate knowledge of the greater stigma surrounding mental health care and OCD, and differences in mental health literacy in various ethnic communities
Evidence: *OR,* Turner et al. (2016); Williams et al. (2017). *CSS*, Chong et al. (2016). *PS*, Williams et al. (2012).

Ability to demonstrate knowledge of common cultural variations in OCD symptom expression
Evidence: *OR,* Williams et al. (2017). *CSS,* Williams and Ching (2017); Williams et al. (2012).

Ability to demonstrate knowledge of stigma and oppression in marginalized ethnic groups (including sociocultural hierarchies, minority experience, racialization, White privilege, caste systems, etc.), and how these may be embedded into obsessional concerns
Evidence: *CSS,* Williams et al. (2012). *AES,* Olatunji et al. (2014); Williams and Turkheimer (2007).

Ability to demonstrate knowledge of the connection between discrimination and OCD
Evidence: *OR,* Williams et al. (2017). *CSS,* Williams et al. (2017).

Ability to demonstrate knowledge that validated OCD measures may be inadequate for diverse populations
Evidence: *CSS,* Wheaton et al. (2013). *PS,* Williams et al. (2013); Chasson et al. (2017); Thomas et al. (2000).

Specialty Competencies:
Ability to utilize culturally informed outreach practices to reach various ethnic and cultural groups for treatment and/or research

Evidence: *OR,* Turner et al. (2016). *CSS*, Williams et al. (2012). *CQS*, Williams et al. (2013). *EO*, Williams et al. (2013).

Ability to demonstrate respect toward diverse patient groups and appreciation of differing worldviews
Evidence: *TM,* Sue et al. (2019). *EO,* Hays (2009).

Ability to distinguish OCD symptoms and comorbidities from normative cultural and religious practices in patients
Evidence: *CR,* Ninan (1993). *EO*, Huppert et al. (2007).

Ability to express understanding of patients' culturally predicated explanatory model for OCD symptoms
Evidence: *CSS,* Grover et al. (2014). *CES,* Pirutinsky et al. (2009).

Ability to demonstrate flexiblility surrounding time, scheduling, and location, to offset barriers to treatment and competing priorities, and to create a comfortable environment for treatment
Evidence: *CSS,* Williams et al. (2012). *CQS,* Williams et al. (2013). *ThP,* Williams and Jahn (2017).

Ability to identify and communicate the role of the family (including extended family) within the context of collectivism/interdependence, and ability to help family members to understand and appreciate treatment to support the patient (e.g., importance of treatment, family accommodations, family-based therapy; see family-based section in this paper)
Evidence: *SR,* Wetterneck et al. (2012). *OR*, Williams et al. (2017). *RCS*, Mehta (1990). *CSS*, Himle et al. (2018).

Ability to translate clinical information into a framework that is compatible with the patient's worldview for understanding and treating OCD, and to communicate that OCD symptoms reflect psychopathology rather than individual differences
Evidence: *CSS,* Williams et al. (2012). *EO,* Rathod and Kingdon (2009).

Ability to identify and communicate understanding of the role of spicompulsion, traditional, and folk healers in the patient's treatment; to demonstrate respect and appreciation of these modalities; and to collaborate with them as necessary and appropriate
Evidence: *EO,* Huppert et al. (2007); Leins and Williams (2018); Moodley and Sutherland (2010); Pouchly (2012).

Ability to devise effective ERP that does not violate a patient's religious faith or core cultural beliefs
Evidence: *CR,* Arip et al. (2018). *EO,* Keshavarzi et al. (2018); Hays (2009); Huppert et al. (2007); Leins and Williams (2018).

3.16 Section name: Relapse prevention

Overview

Although the treatment of OCD has improved over the last decades, with specific effectiveness demonstrated by specialty CBT and serotonin reuptake inhibitors (SRIs), a large proportion of OCD patients show varying degrees of relapse. This section outlines the key knowledge and competencies required for understanding predictors of relapse and for working with patients with OCD with a view towards reducing the likelihood of relapse.

Description of Key Terms

Treatment response: The international expert consensus criteria (Mataix-Cols et al. 2016) for treatment response requires a ≥35% reduction of the individual patient's pre-treatment (C)YBOCS score, plus a Clinical Global Impression – Improvement (CGI-I rating of 1 ('very much improved') or 2 ('much improved'), lasting for at least one week.

Remission: Persons are categorized as in remission when they no longer meet diagnostic criteria for OCD, according to a structured diagnostic interview. If such an interview is not feasible, a score of 12 or less on the (C) YBOCS plus a Clinical Global Impression – Severity (CGI-S) rating of 1 ('normal, not at all ill') or 2 ('borderline mentally ill'), lasting for at least 1 week, is required (Mataix-Cols et al. 2016).

Recovery: The operational definition by this group for recovery is the same as remission, but lasting at least one year (Mataix-Cols et al. 2016). However, as pointed out by Sookman (2018), a

YBOCS score of 12 constitutes wellness (Farris et al. 2013) but not full recovery from illness (YBOCS ≤ 7), and the psychometric and interview criteria for this response category appear to be inconsistent.

Relapse: After response, remission, or recovery is achieved, the patient experiences a return to symptoms. The person's symptoms (a) no longer meet definition of response, remission, or recovery and (b) has a CGI-I rating of 6 ('much worse') or higher for at least one month (or needs to be withdrawn prematurely from a trial before one month has elapsed due to a severe worsening of OCD symptoms (Mataix-Cols et al. 2016)

Level of Evidence

Several studies have investigated predictors of relapse of OCD. These studies include epidemiological studies (e.g., Eisen et al. 2013), meta-analyses (Sharma et al. 2014), medication trials (e.g., Bloch et al. 2013; Catapano et al. 2006; Hollander et al. 2010), and psychotherapy outcome trials (Braga et al. 2010).

These studies suggest that relapse is more likely for patients with comorbid psychiatric conditions (Jakubovski et al. 2013), longer illness duration (Jakubovski et al. 2013), lower doses of treatment (e.g., less time spent in CBT), and lower levels of homework compliance (O'Sullivan et al. 1991). Discontinuation of SRIs monotherapy without CBT is associated with high rate of relapse. Further, some studies suggest that a range of post-treatment characteristics predict relapse (reviewed in Fineberg et al. 2013). For example, some studies suggest that OCD patients are more likely to relapse if they respond poorly to treatment in the first place (Braga et al. 2010; O'Sullivan et al. 1991) or if they remain functionally impaired or symptomatic or have specific types of symptom profiles at the end of treatment (Cherian et al. 2014; Hollander et al. 2010; Nissen and Parner, 2018; Peselow et al. 2015).

There are a few clinical studies reporting on treatment methods to reduce relapse rates; however, most of these studies are single-arm open or pilot trials (e.g,, Hansen et al. 2019; Thiel et al. 2016) or case analyses (e.g., Abramowitz and Arch, 2014; Pascual-Vera et al. 2018). A limited number of randomized controlled trials (RCTs) are available showing that different types of treatment (e.g., SRIs, CBT) may be associated with different rates of relapse following treatment (Fineberg et al. 2018; Strayhorn, 2019). Some RCTs have supported the efficacy of combined or augmenting interventions (e.g., administering CBT in addition to medication), using booster sessions, or reintroducing medication following the acute phase of treatment to reduce relapse (e.g., Andersson et al. 2014; Fineberg et al. 2007; Hiss et al.1994).

Recommendations for Further Research

Despite attempts to explain reasons for relapse (Abramowitz and Arch, 2014), a comprehensive model of relapse in OCD is yet to be developed. Currently, little is known about relapse signatures (risk factors for relapse for an individual) and hence, research on relapse prevention lacks coordination, does not test the efficacy of tailored treatments, and focuses on a wide range of relapse risk factors and prevention methods. Hence, even though some studies have suggested that specific interventions or treatment programs may improve medium- to long-term outcomes (e.g., use of cognitive therapy as well as behavioral interventions that are subtype specific, longer-term specialty CBT) further research is needed to elucidate the mechanisms of such effects. Furthermore, despite the proposal that researchers adopt a common criterion for defining relapse, a number of operational definitions remain in the literature. Further research on relapse prevention should aim to elucidate the contributing factors and what interventions would best reduce this outcome.

RELAPSE PREVENTION **Specialty Knowledge:**
Ability to demonstrate knowledge of treatment continuation and relapse rates
Evidence: *MA*, Sharma et al. (2014). *CS*, Cherian et al. (2014); Eisen et al. (2013); Højgaard et al. (2017).

Ability to demonstrate knowledge of the various ways in which lapses and relapse in OCD are defined and operationalized
Evidence: *MA*, Fineberg et al. (2007). *EO*, Mataix-Cols et al. (2016); Burchi et al. (2018).

Ability to demonstrate knowledge of the implications of different definitions of relapse on conclusions about the superiority of one treatment over another in preventing relapse
Evidence: *MA*, Fineberg et al. (2007).

Ability to demonstrate knowledge of factors that can reduce likelihood of relapse in OCD
Evidence: *MA*, Sharma et al. (2014). *RCT*, Jakubovski et al. (2013). *CS*, Braga et al. (2010); Feusner et al. (2015). *CC*, O'Sullivan et al. (1991); Peselow et al. (2015).

Ability to demonstrate knowledge of methods during and following acute treatment that can result in longer-term maintenance of treatment gains
Evidence: *RCT*, Andersson et al. (2014); Fineberg et al. (2007). *OCT*, Thiel et al. (2016).

Specialty Competencies:
Ability to identify relapse episodes -- that is, when relapse has occurred - using evidence-based definitions and measurement of relapse
Evidence: *RCT*, Andersson et al. (2014). *OCT*, Hansen et al. (2019); Thiel et al. (2016). *TM,* Miller and Rollnick (2013).

TrPN, Larimer et al. (1999).

Ability to distinguish between lapse and relapse
Evidence: *RCT*, Andersson et al. (2014); Hiss et al. (1994). *OCT*, Thiel et al. (2016). *CR*, Abramowitz and Arch (2014); Abramowitz et al. (2013). *TM*, Miller and Rollnick (2013). *TrPN*, Larimer et al. (1999).

Ability to assist patient to identify relapse signatures and road maps – that is, factors that signal a high likelihood of an impending relapse episode
Evidence: *CS*, Tibi et al. (2019) *OCT*, Thiel et al. (2016) *CR*, Sunde et al. (2019); Velikić et al. (2019). *TM*, Miller and Rollnick (2013). *TrPN*, Larimer et al. (1999).

Ability to assist the patient to cope with and manage lapses
Evidence: *RCT*, Andersson et al. (2014); Hiss et al. (1994). *OCT*, Thiel et al. (2016). *CR*, Abramowitz and Arch (2014); Abramowitz et al. (2013). *TM*, Miller and Rollnick (2013). *TrPN*, Larimer et al. (1999).

Ability to reduce "ambivalence" towards change and to motivate patients to consider relapse as a learning opportunity and to return to action-oriented change processes
Evidence: *RCT*, Andersson et al. (2014); Hiss et al. (1994). *OCT*, Thiel et al. (2016). *CR*, Abramowitz and Arch (2014); Abramowitz et al. (2013). *TM*, Miller and Rollnick (2013). *TrPN*, Larimer et al. (1999).

Ability to assist patients to plan for and manage high-risk situations
Evidence: *RCT*, Andersson et al. (2014); Hiss et al. (1994). *OCT*, Thiel et al. (2016). *CR*, Abramowitz and Arch (2014).

TM, Miller and Rollnick (2013). *TrPN*, Larimer et al. (1999).

Ability to pre-empt and reduce chances of relapse by offering relapse prevention programs
Evidence: *RCT*, Andersson et al. (2014); Hiss et al. (1994). *OCT*, Thiel et al. (2016). *CR*, Abramowitz and Arch (2014); Abramowitz et al. (2013). *TM*, Miller and Rollnick (2013). *TrPN*, Larimer et al. (1999).

Ability to assist patients to modify self-percept/esteem and psychosocial functioning in the context of the absence of compulsions
Evidence: *RCT*, Andersson et al. (2014); Hiss et al. (1994). *OCT*, Thiel et al. (2016). *CR*, Abramowitz and Arch (2014); Abramowitz et al. (2013). *TM*, Miller and Rollnick (2013). *TrPN*, Larimer et al. (1999).

3.17 Comment on Co-morbidity in OCD

OCD is characterized by diverse symptom presentations and often is comorbid with other disorders. It is recommended that OCD be treated directly with specialized CBT as soon as possible following emergence of symptoms, with consideration of evidence-based indications for comorbid disorders. As discussed above, delayed or suboptimally treated OCD exacerbates co-occurring symptoms, such as depression, and can have a catastrophic impact on quality of life (Fineberg et al. 2019). Secondary depression and other symptoms generally remit following effective treatment of primary OCD (e.g., sleep disturbance, Nordahl et al. 2018). Treatment of related disorders, anxiety disorders, and unipolar mood disorders, which most frequently co-occur with OCD (Denys et al. 2004), can usually be treated concurrently (e.g., Remmerswaal et al. 2019; Wheaton and Gallina, 2019; Valderrama et al. 2020). Complex or serious co-morbid disorders such as body dysmorphic disorder, PTSD, eating disorder, or borderline personality disorder may require dual focused interventions, with primacy and seriousness of symptoms influencing sequencing of interventions (e.g., Thamby and Khanna, 2019; Castle et al. 2020; Fletcher et al. 2020; Mandelli et al. 2020). Neurodevelopmental comorbid disorders such as Tourette's syndrome, chronic tic disorder, and ADHD necessitate adaptations in approach based on the specific available evidence (e.g., Flygare et al. 2020; Mersin et al. 2020). Disorders that interfere with learning during CBT, such as substance abuse, need concurrent or prior treatment. Situations of risk

related to OCD and/or comorbid disorders may require crisis intervention followed by disorder-specific interventions (e.g., acute suicidality; life-threatening eating disorder; uncontrolled substance abuse, bipolar disorder, or psychotic disorders) (Veale et al. 2009; Albert et al. 2019; Dell'Osso et al. 2020; Mawn et al. 2020; Palombini et al. 2020). Attempts to classify comorbidity in OCD to reduce heterogeneity require further research and replication (e.g., van Oudheusden et al. 2020). Development of algorithms for treatment of comorbidity in OCD is beyond the scope of this paper.

4 Discussion

Current research underlines the importance of direct and timely access to specialized treatment for OCD following emergence of symptoms in order to prevent commonly occurring progression of illness, however, as a field we are falling vastly short of this goal. It has long been widely recognized that, consistent with available guidelines for the treatment of OCD (NICE, 2005; Koran et al, 2007; Koran and Simpson, 2013), clinicians and sites treating this prevalent and disabling disorder should include provision of CBT. Despite these guidelines, and reiteration by professional groups ranging from international (e.g., Menchon et al. 2016) to provincial (e.g., Ontario Health Quality, 2020), accessibility and quality of timely evidence-based CBT for OCD remains very limited across many global regions. A well-documented major cause of this devastating situation is that there are an insufficient number of clinicians and sites qualified to deliver specialized CBT for OCD. The ATF was created to address the urgent need to develop measurable knowledge and competency standards for specialized treatments for OCD deemed by experts to be foundational to transformative change in this field. The knowledge and competency standards presented in this paper, although these are not all inclusive, have been developed to inform, advance, and offer a model for clinical practice and training of specialized cognitive behavior therapy for OCD. These standards will require periodic review and updating commensurate with advances in clinical research.

The concept of recovery, widely addressed for other mental disorders such as depression, is under-examined in the OCD literature and requires concurrent attention (Sookman and Steketee, 2010, Sookman 2016; Mataix-Cols, et al. 2016; Burchi et al. 2018). It has been demonstrated that in response to treatments involving CBT alone and/or in combination with pharmacotherapy OCD is curable in some cases using criterion for recovery of score of ≤ 7 on the Yale-Brown Obsessive Compulsive Scale (YBOCS) plus psychosocial criteria (e.g., Sookman and Pinard, 1999; Sookman et al. 2003; Simpson, et al. 2006; Belloch et al. 2008; Rachman et al. 2015, Nakajima, 2018). Furthermore, achieving wellness at

post treatment predicts stability of improvement (Elsner et al. 2020). Specialized cognitive behavior therapy for adult OCD of longer duration and complexity generally results in greater recovery rates. It should be noted that research treatment trials even at expert sites are generally time-limited and manualized. An optimal trial of CBT for adult OCD often requires longer duration and complexity of specialty interventions. Standardized criteria across treatment sites that include assessment of symptoms, psychosocial functioning, quality of life, and distinction between wellness and full recovery status would be important for clinical and research purposes (Simpson et al. 2006; Farris et al. 2013; Mataix-Cols et al. 2016). Further research to validate and refine promising treatment approaches and randomized controlled trials should examine the intervention and individual characteristics of patients who achieve recovery, compared with those who do not, as well as mediators/mechanisms of change. Given the disabling sequelae of OCD, treatment should include interventions to ameliorate multi-dimensional skills deficits and other obstacles to developmental growth and accommodation with the aim of improving resilience, flexibility, and self-efficacy (Sookman, 2016). As was advised many years ago (Rachman, 1983), a crucial distinction should be made between technical treatment failure, when an individual does not improve due to the inadequacy of treatment, and serious treatment failure, when an individual does not respond to adequately delivered treatment.

The ATF knowledge and competency standards have been developed to inform, advance, and offer a model for clinical practice and training in this field. These are foundational to upcoming phases three and four of the ATF initiative: development and implementation of criteria and processes for training to the level of certification (individual clinicians) and accreditation (clinical sites), based on the established ATF standards. The upcoming phases are deemed by experts to be needed because training in general psychiatry, psychology. and/or cognitive behavior therapy (CBT) may often be insufficient to acquire the clinical skills required for specialized CBT for varied OCD symptoms subtypes and related difficulties. Excellent programs that provide training in CBT for OCD have been developed at specific expert sites with promising results (e.g., Jacoby et al. 2019). However, current widely used training models such as educational and training workshops, while helpful to communicate diagnostic issues and basic treatment interventions, generally cannot cover the complex skills required for effective specialized practice. There are an insufficient number of academic training programs that offer treatment of OCD as a training elective to our next generation. Improvement of existing models of training, including reliable evaluative methods to examine their efficacy, are required to disseminate advanced specialty clinical skills needed to optimize illness recovery for as many patients

as possible, which ATF phases three and four will address.

More specifically, during the upcoming phases the ATF will develop criteria to assess clinician knowledge and competencies with OCD, including minimal recommended training, supervision, and evaluative processes. Multi-site creation and validation of a standardized scale to assess clinician knowledge and competencies for OCD is planned. A distinction will be made between certification levels, that is, between competency and expert levels. Establishment of criteria for accreditation of sites (i.e., more than one certified clinician working together) will build upon and require prior establishment of certification for individual clinicians.

Many OCD patients are labelled as treatment-resistant or refractory as a result of technical treatment failures after prolonged waiting to access treatment that is not evidence based. Ineffective and/or delayed treatments worsen intransigence of illness, progression to disability, suffering of patients and their families, unsuccessful health care utilization, feelings of hopelessness, and secondary depression that may be associated with suicidality. While research is ongoing to increase the clinical armamentarium of OCD experts, operationalization and dissemination of specialized knowledge and competencies available at expert sites is urgently needed to achieve transformative change in this field. We hope that the ATF phase two establishment of specialty knowledge and competency standards recommended for specialized treatments for OCD – as presented in this paper and the others in this special series -- will constitute a significant step forward.

Acknowledgements

Thank you to Dr. Penny Bee for her contribution of information regarding low intensity treatments for OCD provided through IAPT in UK; and to Dr. Mike Kryrios for his contribution to an earlier draft of the conceptualization section in this paper. Appreciation to Ms. Danielle Rice for her dedicated collaboration as research assistant for the ATF phase two papers, and thanks to research assistant Amber-Lee Di Paolo.

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