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INTRODUCTION

Treatment of Obsessive-Compulsive Disorder: Beyond Behavior Therapy

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Obsessive-compulsive disorder (OCD) is characterized by obsessions, compulsions or, most typically, both (American Psychiatric Association (APA), 2000). Obsessions are upsetting thoughts, images, or urges that intrude, unbidden, into the person’s stream of consciousness. Examples include unwanted thoughts of harming loved ones; persistent, unwarranted doubts that one has properly locked the front door; or intrusive thoughts of being contaminated. Compulsions are repetitive, intentional behaviors or mental acts that the person feels compelled to perform, usually with a desire to resist. Compulsions are typically intended to avert some feared event or to reduce distress. They may be performed in response to an obsession, such as repetitive checking evoked by obsessions about having not properly locked the door. Alternatively, compulsions may be performed in accordance to certain rules, such as checking the door by locking and unlocking it 6 times before leaving. Compulsions are excessive or not realistically connected to what they are intended to prevent (APA, 2000).

OCD has a lifetime prevalence of 2–3% (Weissman et al., 1994). It often begins in adolescence or early adulthood, usually with a gradual onset (APA, 2000). The disorder tends to be chronic if untreated, with symptoms waxing and waning in severity, often in response to stressful life events (Rasmussen & Eisen, 1992). The disorder is equally common among women and men (APA, 2000).

Modern advances in understanding and treating OCD began during the 1960s and 1970s, with the development of conditioning models to the disorder (e.g. Rachman, 1971; Teasdale, 1974). These were based on Mower’s (1960) 2-factor theory of fear, and proposed that obsessional fears were acquired by classical conditioning and maintained by operant conditioning. According to these models, the obsessional fear of acquiring a serious illness from doorknobs, for example, would arise from a traumatic experience whereby a loved one purportedly acquired such a disease (the unconditioned stimulus) from contact with a “dirty” doorknob in a public place (the conditioned stimulus). Obsessional fears were said to be maintained by negative reinforcement; that is, avoidance of doorknobs or compulsive washing after coming into contact with a doorknob. Here, the avoidance or compulsive ritual is negatively reinforced by the reduction in discomfort and by a reduction in the perceived probability of feared consequences such as becoming contaminated.

Conditioning models led to what has been established as one of the most effective treatments for OCD (March et al., 1997); a behavioral therapy that became known as exposure and response prevention (ERP; Meyer, 1966). This treatment involves exposure to harmless but fear-evoking stimuli, while delaying or refraining from performing the compulsive rituals.
Although conditioning models led to important advances in understanding and treating OCD, the models and ERP had important limitations. The models had difficulty explaining many of the features of OCD, such as the fact that many OCD patients, for example, do not have a history of relevant conditioning experiences that might lead to obsessional fears (Taylor et al., in press). Problems were also encountered with ERP. Some patients are unable or unwilling to tolerate the distress associated with ERP, and not all treatment completers benefit from this intervention.

The purpose of this special issue of *Cognitive Behaviour Therapy* is to consider the important methods that have been proposed to enhance the treatment of OCD. That is, therapy protocols that allow clinical practitioners to move beyond the established behavioral treatment – ERP – to treat OCD more effectively. The methods considered in this special issue include cognitive-behavioral models and treatments as alternatives to conditioning models and ERP, as well as adjunctive treatments that can be combined with ERP to improve outcome.

Treatment alternatives to ERP have been derived from contemporary cognitive-behavioral models of OCD. These models fall into 2 broad classes; those proposing that OCD is due to some dysfunction in cognitive processing (general deficit models, such as the inference model described by Kieron O'Connor et al. in this special issue) and models postulating that specific dysfunctional beliefs and appraisals cause OCD (belief and appraisal (B&A) models; see Clark, this issue). Both types of models have led to promising cognitive or cognitive-behavioral treatments of OCD.

The opening paper, by David Clark, discusses the nature, rationale and merits of contemporary B&A-based treatment. The next paper, by Jonathan Abramowitz et al., provides an independent and somewhat different perspective on the merits and indications for B&A-based interventions. In the third paper, O'Connor and colleagues describe their inference-based model and treatment. O'Connor et al. also describe the results of the first randomized, controlled study of the efficacy of their treatment.

The remaining papers in this special issue consider interventions that can be combined with ERP or cognitive-behavioral interventions to improve treatment outcome. Keith Renshaw and colleagues consider the interpersonal context of OCD, and discuss whether family-based interventions can improve treatment outcome. Nicholas Maltby and David Tolin discuss the use of motivational enhancement methods to help encourage patients to complete ERP exercises. Jean Cottraux and colleagues discuss the methods and merits of combining particular pharmacotherapies with ERP or cognitive-behavioral treatments. In the final paper, Cheryl Carmin comments on each of the papers in this special issue, to provide a “big picture” perspective on how we can improve treatment acceptability and efficacy for OCD.

**References**


