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Severe OCD

Jonathan D. Huppert and Edna B. Foa

Keywords: OCD, obsessions, compulsions, exposure, insight

Obsessive–compulsive disorder (OCD) is an anxiety disorder characterized by both obsessions and compulsions. Obsessions are intrusive thoughts, images, or impulses that come into one's mind for no apparent reason, are unwanted, and are distressing. Compulsions are characterized by repeated behaviors or thoughts that serve to decrease the obsessional distress. To meet criteria for OCD, obsessions and/or compulsions must take up at least 1 hour a day and be distressing or interfere with the patient's functioning in life. Severe OCD is characterized by substantial frequency of obsessions and compulsions (from 4 hours a day to every minute of the patient's waking hours), substantial impairment from the OCD (usually in all domains of life including social, work, and family), poor insight into the symptoms (or how realistic the patient thinks their fears are), and/or substantial comorbidity which complicates the presentation of the symptoms (e.g., posttraumatic stress disorder or schizophrenia).

Severity of symptoms, as characterized by high frequency of symptoms or significant distress, is often measured by the Yale–Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989), and can also be measured through self-report measures such as the Obsessive–Compulsive Inventory-Revised (OCI-R; Foa et al., 2002). Either of these scales may not capture all severe cases; however, administered together, the large majority of severe cases should be detected.

Poor insight, also known as overvalued ideation (OVI; Kozak & Foa, 1994), is also a predictor of worse outcome for CBT. OVI is assessed through the Y-BOCS, but also can be assessed using a number of measures including the Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998). The main characteristic of OVI is that the patient is convinced that his or her obsessional fears are realistic. A classic example is a patient who believes that touching doorknobs really can lead to contracting AIDS. Such a patient will often state that he or she is just extremely careful. For patients with extreme OVI of this type, most people in the world are viewed as careless, and they are either lucky that they have not contracted AIDS or may have it and not be aware because they have not had an AIDS test. Most patients with OVI will acknowledge that other people think differently, but attribute this difference to the idea that others are wrong. Patients with severe OVI may appear delusional, but they present differently than patients who have a co-occurring psychotic disorder such as schizophrenia.

Comorbid disorders may exacerbate OCD symptoms and make it harder to treat. There are few data on the treatment of OCD and comorbid schizophrenia with CBT, but our clinical experience suggests that most patients with schizophrenia who have co-occurring OCD do not benefit from exposure and ritual prevention. Recent studies have suggested that patients with severe depression (i.e., the top 10% of depressed patients; Abramowitz, Franklin, Foa, Gordon, & Kozak, 2000) or PTSD (Gershuny, Baer, Jenike, Minichiello, & Wilhelm, 2002) may respond less well to CBT. Depression has been found to interfere with habituation in patients with OCD, and may also interfere with cognitive changes. In such cases, treatment of the comorbid disorder either prior to conducting CBT for OCD or simultaneously may be indicated.

Standard CBT for OCD involves the use of exposure and response (ritual) prevention with cognitive processing (Foa & Wilson, 2001). The basic concept underlying the treatment is that patients with OCD attempt to avoid or escape their obsessional fears through a number of strategies including thought suppression, mental and behavioral compulsions, safety behaviors, and avoidance. All of the avoidance behaviors function to decrease or avoid anxiety in the short run, but perpetuate the vicious cycle of anxiety in the long run. Exposure encourages the patient to confront the fears, and ritual prevention serves to prevent the patient from engaging in behaviors that are intended to decrease anxiety and/or to prevent feared consequences. Through this treatment the patients learn that the feared consequences do not occur and their anxiety decreases even when confronting fears and not ritualizing. This new information creates new associations in the fear structure of the patient which become predominant through repeated exposure, rendering the pretreatment fear structure less likely to be activated (Foa & McNally, 1996), and thereby decreasing symptoms.

There are two types of exposure: in vivo and imaginal. In vivo exposure is direct confrontation with feared stimuli

(turning on your stove and leaving the room on purpose or touching a doorknob, toilet, etc. without washing hands). In vivo exercises are usually conducted in a hierarchical fashion, beginning with less distressing situations and gradually moving on to the most distressing situation. The rate of progress up the hierarchy is dictated by the patient's ability to tolerate distress, the frequency of symptoms, how impaired the patient is, and the extent of OVI.

Imaginal exposure is conducted mainly with patients who are afraid that terrible consequences will occur in the future or if the intrusive thoughts are not fully activated through in vivo exposure. For example, the fear of going to hell after death cannot be confronted in real life and therefore cannot be disconfirmed via in vivo exposure. To habituate these kinds of fears, an individualized scenario about 15 minutes long is created for the patient in which the feared consequence occurs because the patient chose not to engage in rituals or avoidance (e.g., a patient chooses to use a steak knife with dinner and does not pray when she thinks about harming her family and therefore she ends up killing the whole family and serving a life sentence all because she lost control when eating steak). Imaginal exposures are usually introduced relatively early on in treatment and are further developed for the patient as necessary throughout the course of treatment.

For both types of exposure, it is essential that the patient refrain from ritualizing in response to the obsessional fears that are evoked by exposure either during or after the exposure. Frequently, all ritualizing is banned from the outset of treatment. Many patients with severe OCD symptoms are unable to cease ritualizing, but they may be able to decrease their compulsions significantly. In these cases, the therapist uses the hierarchy of exposures conducted in session to determine what rituals to ban between sessions as the patient engages in homework and naturalistic exposures. Thus, by the time the patient has reached the top of the hierarchy, he or she is actively trying to cease all rituals as well.

A significant amount of cognitive processing is conducted when treating patients with OCD with exposure and response prevention. Severe cases often require even more emphasis on cognitive processing. Most cognitive processing is conducted during in vivo exposures or after imaginal exposures. The main purpose of cognitive processing is to help the patient to process his/her cognitive and emotional reactions to the exposure. There are two main judgment biases that patients with anxiety disorders, including OCD, have: probability and cost. Patients overestimate the likelihood that negative outcomes will occur ("There is a 99% chance that I will get AIDS if I touch a public bathroom doorknob and do not wash my hands immediately"), and they overestimate the cost of negative outcomes ("If my handwriting is not perfect, then it will be illegible to the professor, and I will fail the exam"). In vivo exposures are particularly useful at decreasing immediate overestimated probability of a fear, while imaginal exposures help to gain perspective and thus reevaluate long-term probability of feared outcomes and to differentiate between thoughts and actions. It is important that the patient conducts assigned exposures daily during treatment.

Originally, most forms of CBT for OCD were conducted with daily exposure sessions with a therapist (e.g., Meyer, 1966). However, recent studies have suggested similar efficacy for patients who are treated twice weekly (Abramowitz et al., 2003). However, patients with severe OCD symptoms seem to benefit more from intensive daily treatment, as it allows the therapist to troubleshoot any problems on a daily basis and it promotes the patient's motivation for improvement. Patients whose OCD is so severe that it prevents them from participating in outpatient treatment may benefit from treatment delivered in an inpatient unit that specializes in the treatment of OCD. Such units usually have aides who assist the patient with their treatment plan 24 hours a day, and help the patient to fully engage in treatment. Most severe cases of OCD require intensive therapist involvement in the treatment, and weekly sessions or self-help regimens are likely insufficient. If a patient is willing to tolerate distress, highly motivated to change, not depressed, and has a healthy family environment that will be supportive of change, then less intensive treatment may be sufficient.

In most cases, it is useful to involve the patient's family in the treatment. In more severe cases, it is typical that the family is involved in ritualizing for the patient either through reassurance, assisting in avoidance, or by explicitly conducting rituals for the patient. The therapist needs to use clinical judgment about the degree of family involvement in the treatment. In most cases, family members should be encouraged to give emotional support to the patients. In some cases, however, the relationship between the patient and family members is so strained that it is more advisable for them to not get involved in the treatment and homework exercises. For most families, at least a single session of psychoeducation about the CBT model of OCD is advisable.

A substantial proportion of patients with severe OCD benefits from CBT. However, patients who are unable to tolerate distress, have severe OVI, are not motivated to change, or have severe OCD of the hoarding subtype seem to respond less well to treatment. Some suggestions have been made to include motivational interviewing to help to address all of these problems.

See also: Body dysmorphia 1, Body dysmorphia 2, Exposure therapy, Perfectionism

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Sex Offending

Christine Maguth Nezu and Jeffrey G. Stoll

Keywords: sex offending, rape, child molestation

Sex offending behavior is a serious and widespread public health problem that has a lasting and profound impact on its victims. At any given time, the majority of convicted offenders are not in prison but are currently under the supervision of law enforcement and living in the community. This situation has led to a growing demand for effective sex offender treatment and a challenge to cognitive–behavioral researchers to attempt to better understand why men rape women or molest children, from both a functional and a causal perspective.

EXPLANATORY BEHAVIORAL MODELS

Over the years several behavioral explanatory models of sexual aggression have been proposed. Early models were based on theories of conditioning and deviant arousal. This "sexual motivational conditioning" model proposed that deviant sexual behavior occurs because the offender's early deviant sexual fantasies are paired with masturbation (Maguire, Carlisle, & Young, 1965). Although many sex offenders may be diagnosed or identified as exhibiting deviant sexual interests, the presence of such interests does not always equal engagement in sex offending behavior. For example, some individuals with paraphilias, defined as recurrent, intense, sexually arousing fantasies, urges, or behaviors that are consensually specified as deviant and result in distress, do not actually engage in behaviors consistent with their urges (Lanyon, 2001). It is also possible for a person to legally offend but not express specific paraphilic interests. Therefore, sexual conditioning does not fully account for the range of sex offending behavior.

Other models that attempt to explain sex offending focus on the aggressive aspect of the behavior, listing emotional dyscontrol and poor coping skills as problems related to offending. Some of these models have focused on the offender's lack of social competency or the role of learning through aggressive models (Marshall, Anderson, & Fernandez, 1999). Through these social cognitive processing theories, the sex offender is seen as a person who lacks social and interpersonal skills, such as social problem solving, and uses sexual aggression to solve their personal problems. Additional models that may help to explain sex offending focus more on interpersonal vulnerabilities that result from the offender's developmental antecedents (history), such as the offender's own history of physical or sexual abuse or unpredictable and neglectful family backgrounds. These developmental theories suggest that offenders have a poor ability to form interpersonal attachments to other people (Hall, 1996). For example, with regard to how a given offender may learn to cope with his own history of physical or sexual abuse, he may see himself as alone in the world, where he must fight and control others, before he is hurt or victimized. He may have no desire to change.