What's Broken with Cognitive Behavior Therapy Treatment of Obsessive–Compulsive Disorder and How to Fix It

AVIGDOR BONCHEK, Ph.D.

Cognitive Behavior Therapy (CBT) *is the evidence–based treatment of choice for Obsessive–Compulsive Disorder (OCD). The central technique of this approach is Exposure and Response Prevention (EX/RP). Examination of EX/RP treatment of OCD reveals severe shortcomings. The technique, while generally quite effective, cannot deal with patients who are unable to comply with EX/RP's difficult regime, resulting in a significant percentage of patients who refuse treatment and dropouts. Also, for optimal results, the therapist should be present while the patient carries out EX/RP therapy. This severely reduces the therapist's resources since leaving the clinic and being personally present during EX/RP in the patient's real life circumstances is not something therapists can do easily. These limitations acutely compromise the applicability of this technique to clinical practice. Research into Cognitive Therapy without EX/RP does not show superiority to EX/RP. In this paper, I illustrate a Strategic/Behavioral Treatment (SBT) for OCD that easily and elegantly overcomes the limitations of Cognitive Behavioral Therapy (CBT) treatment (thereby increasing its effectiveness), present three case studies, and offer suggestions for further research.*

KEYWORDS: obsessive–compulsive treatment; exposure/response prevention; strategic/behavior therapy; prescribing the symptom

"WHAT'S BROKEN WITH COGNITIVE BEHAVIOR TREATMENT OF OBSESSIVE–COMPULSIVE DISORDER AND HOW TO FIX IT"

One of the most notable achievements—if not the most notable—of psychiatry and psychology in the latter decades of the 20th century has been the significant improvement in treating Obsessive–Compulsive Disorder (OCD). Once considered as an intractable disorder (Black, 1974) in

Director, Jerusalem Center for Anxiety Disorders. ***Mailing address:*** P.O. Box 18136, Jerusalem, Israel. e–mail: drbonchek@gmail.com

the 1970s, today OCD is one with several medical and psychological treatment options that have been shown empirically to bring at least some relief to the suffering of patients. In the realm of psychopharmacology, the advent of Selective Seritonin Reuptake Inhibitors have been helpful in bringing partial, and sometimes significant, relief in most cases of OCD. In the area of psychotherapy, professionals and professional associations recognize Cognitive Behavioral Therapy (CBT) as the state–of–the–art psychological treatment for OCD (Chambless, Baker, Baucom, Beutler, Calhoun, Crits–Christoph *et al.*, 1998; March, Frances, Kahn & Carpenter, 1997). Much research has been devoted to demonstrating CBT effectiveness in symptom relief. It is one of the best evidence–based treatments in the field of psychotherapy.

In this article I examine Exposure and Response Prevention (EX/RP), the main CBT technique for treating OCD; review the acknowledged limitations of the technique; explain the reason for these limitations; address the issue of patient noncompliance; examine the contribution of Cognitive Therapy and its acknowledged shortcomings; describe a Strategic/Behavioral (SBT) technique that avoids these shortcomings; introduce the SBT therapeutic approach to clinical problems; report on three cases studies using these techniques and method; and propose suggestions for further research directions.

CBT'S MAIN TECHNIQUE FOR OCD–EXPOSURE/RESPONSE PREVENTION

The main CBT technique used for symptom reduction has been Exposure and Response Prevention (EX/RP). The technique, originally reported by Meyer (1966), requires the patient to expose himself to situations that increase his anxiety (exposure), which, as a consequence, increases his urge to compulsively ritualize. He is then requested to refrain from ritualizing, *i.e.,* from performing his compulsion (response prevention). Various studies report success rates of EX/RP in the 50% to 60% range (Fisher & Wells, 2005). "Success rates" in these studies focus on statistically significant symptom reduction, but as Abramowitz (1998) has pointed out, symptom reduction in and of itself does not necessarily mean clinically improved functioning. Abramowitz (1998), by means of a meta–analysis of selected studies, attempted to determine if symptom reduction as a result of EX/RP lead to clinically improved functioning. His conclusion: "it appears that while some patients who undergo cognitive–behavior treatment by EX/RP do experience functional, or clinically significant,

improvements in their OCD symptoms, there are still a number of others who do not" (Abromowitz, 1998, p. 350).

Despite this equivocal support for EX/RP, the technique remains the most empirically supported psychological treatment for OCD.

Limitations of EX/RP

However, the technique has limitations, which can be summarized in three points. First, it has been estimated (Abramowitz, 2006) that the total of "refusers," drop outs, failures, and relapses are about 50%. Thus, only about half of those who turn to CBT practitioners for help, improve. Considering this high drop–out rate, Riggs and Foa (1993) advise that [we find] "methods for increasing motivation and improving existing treatments" (p. 235).

The second problem with EX/RP, which is most likely the reason for the high drop out rate, is that the essence of EX/RP is to have the person confront his compulsion head on. The irony here is that the patient seeks help because he has tried, but was unsuccessful, in stopping his compulsive ritualizing, and we treat him by asking him to "Stop ritualizing!" Why such straight, no–nonsense psychological advice should work at all is the wonder (more so than why EX/RP works only 50% of the time).

The reason EX/RP works to the extent that it does seems to be that the therapeutic program includes two elements the patient most likely had not previously tried. These are *initiating* exposure to the feared situations, as opposed to reluctantly suffering unplanned, unintentional exposure in real–life circumstances. The other therapeutic element is the *graduated* confrontation of low–anxiety situations. A third, rarely acknowledged, factor is that patients with OCD seem to possess more flexibility and inner strength than they are given credit for in preventing compulsive responses. These important therapeutic elements undoubtedly enable the EX/RP procedure to succeed to the extent that it does.

The third problem with EX/RP is that this technique is most successful when done in the presence of the therapist (Abramowitz, 1996). The centrality of personal supervision by the therapist in using EX/RP can be seen in Meyer's (1966) first report of this technique. He writes:

> In order to make the supervision easier and more effective, the [water] taps in her room were turned off and a strict control over her cleansing agents exerted. Persuasion, reassurance and encouragement were used to prevent the patient from unnecessary and excessive washing and cleaning (p. 277).

This is probably why the technique is termed "response *prevention*" and not "response *inhibition*"—because the response was actually pre-

vented by the therapist turning off the water, rather than the patient inhibit the response herself. Today therapists rarely prevent the compulsive response outright; instead, they encourage, cajole, reassure, and persuade. This is why the therapist's presence often is necessary with the more difficult cases.

It seems that patients with mild cases would respond without therapist participation, while those with more severe OCD disabilities respond only when there is "hands–on" therapist involvement. Those who need direct therapist involvement, which frequently cannot be done in the clinic, would require the therapist to work outside the office. This, consequently, limits the therapist's ability to treat many patients.

THE ISSUE OF PATIENT NON–COMPLIANCE

The CBT approach to patient noncompliance reflects its overall conception of the therapist– patient relationship. Franklin and Foa (2008) instruct the therapist on how to relate to and what to say when the patient does not do EX/RP homework assignments.

> It seems that right now you aren't able to stop ritualizing. For treatment to be successful, it is essential that you *completely* stop your rituals. Every time you relieve your discomfort by ritualizing, you prevent yourself from learning that anxiety would have declined eventually without rituals, and you don't permit your obsessional fears to be disconnected from distress and anxiety. . . It is a very hard for people to resist the urge to ritualize and it may be that you are not ready yet and will feel more able to do so in the future (p. 205 [Emphasis in original]).

This didactic approach to communicating with the patient reflects the therapeutic attitude of CBT, which assumes that the patient is a fully rational individual who can be spoken to as an eager student. While it is certainly true that many OCD patients are rational individuals and intellectually capable of understanding directions, it is not true that they can think and act in ways not influenced by their emotional state, *in matters relating to their OCD problems.*

Foa tells the patient: "For treatment to be successful, it is essential that you *completely* stop your rituals" (p. 205). It is almost as if the therapist forgot that the patient came for professional help precisely because he could not stop ritualizing completely! If he could, he would not have sought help.

It would seem that the noncompliant patient needs a different, shall we say, more psychological approach? The point of this paper is to suggest

methods to deal with the problem of noncompliance therapeutically; I will expand on this later.

Despite the successes of EX/RP, its shortcomings have prompted clinicians and researchers to investigate other treatment options.

PURE COGNITIVE THERAPY (CT): RESEARCH FINDINGS & LIMITATIONS

In the last decade, an increasing number of researchers have investigated the new Cognitive Therapy (CT) techniques, excluding behavioral EX/RP, for treating OCD. The purported benefits of CT over EX/RP are the ability of the clinical work to be done in the therapist's office and fewer "refusers" and drop–outs, since patients are not challenged with the *in vivo* confrontations with their fear, as is done with EX/RP.

The CT approach to treating OCD relies on two basic assumptions; these are: 1) cognitions and cognitive styles are important causal factors in the development and perpetuation of compulsions and obsessions, and 2) Cognitive Therapy techniques are most effective for treating these errant cognitions.

Underlying these assumptions is a belief that the patient operates on a rational level and he can think rationally about his compulsions if given guidance. The cognitive techniques used in CT are similar to Socratic dialogue, *i.e.*, a rational questioning of the individual about his irrational problem. The approach places much confidence in the patient's ability to analyze rationally his mistaken thinking processes. By showing the patient where his thinking has gone wrong, the therapist assumes that the patient will be able to abandon his obsessions and compulsions. This, in effect, is a rational approach to a very irrational psychological phenomenon.

Unfortunately to date these assumptions have not been supported by research (Anholt, Kempe, de Haan, van Oppen, Cath, Smit *et al.*, 2008).

Emmelkamp (2002), a pioneering researcher of Cognitive Therapy for OCD, summarizes the research findings:

> Little evidence is yet available with respect to changes in cognitions as a result of behavioral treatment. . . Perhaps even more disappointing, of the seven subscales used to assess cognitive changes only [one] was found to improve more than in non–treatment control conditions. Further, none of the cognitive measures predicted improvement. . . [and] it is far from clear yet whether cognitive therapy is the only way to achieve those changes in beliefs (p. 462).

More recently, Wilhelm and Steketee (2006) summarized the findings

in this area. They reflect a more positive view, which is, nevertheless, a qualified one.

> In summary, research on the effectiveness of CT treatments indicates that these methods are quite effective in treating OCD, probably as effective as EX/RP... Nonetheless more research is needed to fully establish the efficacy and mechanisms of change in CT... *We are not yet sure whether CT will be an effective alternative therapy for patients who have not benefited from EX/RP.* However, since there are few alternatives, clinicians may certainly wish to try CT with patients who fail EX/RP treatment (pp. 16, 17 [Emphasis added]).

Taken together, Emmelkamp's and Wilhelm and Steketee's summarizations are disappointing conclusions, considering all the research efforts that have been expended to substantiate the efficacy of Cognitive Therapy for OCD.

CT IS A RATIONAL APPROACH TO AN IRRATIONAL PROBLEM

As said previously, the cognitive approach is a rational one that attempts to correct the patient's irrational obsessions and compulsions by conducting an essentially rational dialogue. Of course, the big question remains: is there validity to these assumptions? An objective answer must be: the literature does not necessarily support this assumption. It might very well be that for the serious cases of OCD, rational dialogue is an insufficient method to bring about change.

A recent statement from Beck (Young, Weinberger & Beck, 2001), the founder of Cognitive Therapy, regarding his classic cognitive work on depression is informative:

> Behavioral techniques are used throughout the course of cognitive therapy, but are generally concentrated in the earlier stages of treatment. Behavioral techniques are especially necessary for those more severely depressed patients who are passive, anhedonic, and socially withdrawn and unable to concentrate for extended periods of time (p. 281).

If the patient suffers from these symptoms Beck tells us that cognitive techniques alone are not sufficient to bring relief; behavioral techniques are necessary to accomplish relief. It is possible that for sub–clinical cases of depression cognitive methods are sufficient, while more serious cases require behavioral techniques to achieve relief.

It is revealing to note that Beck, himself, did not rely on cognitive techniques alone to treat compulsions. Following is what he wrote about treating a compulsion:

> In treating such cases (of OCD), I have set up a procedure of inducing the

> patient to touch a dirty object in my presence, but, by prior agreement, I eliminate the opportunity for his washing his hands. Deprived of the mechanism for ridding himself of the supposed germ-laden dirt he begins to visualize himself in the hospital dying of a dread disease. (Beck, 1976, pg. 18)

This looks like a typical description of Exposure and Response Prevention, the basic behavioral approach for treating OCD today, yet it comes from Dr. Beck, the originator of Cognitive Therapy, in 1976!

Beck's statements, taken with Wilhelm and Steketee's and Emmelkamp's summarizations indicating the paucity of research evidence for CT, may well point to inherent limitations of pure Cognitive Therapy. As I have said, findings so far have yet to establish the clear reparative effects of cognitive techniques on their own without behavioral elements.

ANALYZING THE EX/RP TECHNIQUE ... THE EMPEROR'S CLOTHES

When we analyze the EX/RP behavioral technique closely, *sans* its sterilized academic terminology, (*i.e.* "response prevention", "emotional habituation", etc.) we see the astonishing simplicity of it all.

As pointed out above, the central pillar of EX/RP is to have the patient refrain from performing his compulsion despite his tension. How is this different from telling any person with any behavior problem that to cure the problem he must simply stop it? Imagine, for example, treating a man to stop his being physically abusive towards his wife. As an integral and central part of the therapy, the therapist gives the patient and his wife a homework assignment. They are told that should the wife do something that might provoke her husband (Exposure), the husband should refrain from beating her (Response Prevention). When he successfully refrains from beating his wife for three consecutive weeks, the husband will have made great progress in controlling his abusive behavior.

This same EX/RP paradigm can be used for a multitude of psychological problems. The bulimic can be exposed to junk food and requested to refrain from induced vomiting; the addict can be exposed to his temptation and told to refrain from his addictive behavior; and the overeater can be exposed to food and asked to refrain from overeating behavior. The list of therapeutic opportunities to apply EX/RP could go on.

All of this is not to say that such straightforward, no nonsense, therapy could not work, it is only to say that having the patient comply with these instructions would usually be quite difficult. This, in fact, seems to be the

Achilles' heel of EX/RP and the reason for the high percent of "refusers" and dropouts.

STRATEGIC THERAPY'S CONTRIBUTION: "PRESCRIBING THE SYMPTOM"

Strategic therapy is a new approach for treating OCD. Its unique contribution is that it recognizes the patient's compliance as a *sine quo non* for therapy to be effective. It takes at its first therapeutic challenge the reduction or elimination of patient resistance. While Strategic therapy is a well–documented approach used in family therapy (Haley, 1976; Madanes, 1981; and others), it is less well known as an appropriate approach for treating clinical disorders.

The Strategic Approach is considered "nonlinear," meaning that its stratagems are often counterintuitive; they deal with the irrationality of psychopathology in ways that likewise seem irrational. The Strategic Approach makes use of techniques such as paradoxical injunctions, double bind communication, the illusion of alternatives, and prescribing the symptom. It aims at reducing resistance and encourages compliance in a variety of ways, mainly through subtle communications that bypass the patient's critical tendencies. Nardone, in his Strategic Therapy clinic in Arezzo, Italy, has demonstrated the application of Strategic therapy to a variety of clinical (DSM) disorders, among them OCD (Nardone, 1996; Nardone, & Watzlawick, 2005; Nardone, Milanese & Verbitz, 2005; Nardone & Salvini, 2007).

But even before Nardone, there is a brief record of the strategic procedure of "prescribing the symptom" applied to cases of OCD. Rabavilas, Boulougouris and Stefanis (1977) reported using this technique with four checking–compulsive patients. The four compulsives were instructed: "That when they felt compelled to check more than once, they were to continue checking beyond the point imposed on them by their compulsion. They were to continue checking another 50 times" (p. 111). Their unexpected finding was that *not one of the patients* performed this technique because *not one of them was interested in checking beyond one time*! Strangely, in spite of his surprising success, there have been no other reports in the journal literature of this technique used for OCD. Several decades later, Nardone (1996) began reporting his work in Europe.

The concept of "prescribing the symptom" is that the person has to repeat his symptomatic behavior as prescribed by the therapist. For example, a person with a hand washing compulsion would be instructed in the following way:

> You should try not washing your hands more than one time. But if the urge is too strong to resist, which I can understand that it might be, then you may wash your hands as many times as you feel necessary. But then when you are satisfied that you have washed enough, you are to wash *five (or ten or more) more times*.

The author used this simple technique, which I will call, Exposure and Response Repetition (EX/RR) with several patients who suffered from OCD. Brief case reports follow.

CASE STUDIES

Case #1

A 15–year–old, male, high–school student evidenced several compulsive behaviors, excessive hand washing, compulsive adjusting of his eyeglasses, and a nightly ritual of cleaning his bed by shaking out the blanket and brushing off the sheets several times. I asked him which of the compulsions he wanted work on first. He chose the bed–cleaning problem because it brought him into conflict with his older brother, who slept in the same room. I instructed him to try to get into bed without the bedtime ritual (the EX/RP technique) and record his "successes." At the next session, when it was clear that he could not refrain from performing the ritual, I instructed him: "Each night that you feel you have to clean off your bed, do it as much as necessary, and then do it *five more times.*"

At the next session he was happy to report that he was able to do it five more times as instructed. He was then told: "Great! Now for the next week if you want to do the cleaning, go ahead and do it, and when you're finished then do it *10 more times.*" He agreed.

The following week he complained that it was getting to be too much to do. I expressed my disappointment and said I had actually expected to increase it to 15 times. He pleaded not to. I agreed, but only on the condition that he get straight into bed without any "cleaning." If he didn't keep this agreement, he was told that we would go back *to 15 times more.* He stopped the ritual completely (as testified by his mother) and has not reverted to the compulsion for more than a half year.

Case #2

A 21–year–old, religious, female college student had a hand–washing compulsion; she would wash with excessive amounts of soap after every visit to the bathroom, when coming in from outside, or whenever she felt "dirty." Because of her doubts she would wash again and again, each time with more liquid soap. She also had problems with repeating prayers and

had difficulty getting out of the house on time. If she planned to leave the house by 10:30 A.M., she would have to give herself at least two hours to prepare—and she would still be late to work or school because she would, nevertheless, leave the house much later than planned.

We began our work, at her preference, with limiting her hand washing to two squirts of soap. First, I asked her to try her best not to rewash and to keep a record of this (EX/RP). She showed some improvement by the mere request of response prevention, but there were many times she could not follow my instructions. I instructed her that if she had to wash her hands, she could until she no longer felt the need—then she was to wash *three more times*. A week later she reported improvement. Her spontaneous comment is instructive: "Several times I wanted to wash again but I didn't want to wash three more times so I didn't even wash once more!" In another three weeks she was able to gain control of her hand washing, without the need to rewash.

W used this technique for her obsessive inability to get out of the house at the time she planned. I asked her to decide the time she wanted to leave the house (and record it) and then once she actually walked out of the door, she was to note by how many minutes she exceeded the time. She was to reenter the house and wait the same amount of minutes before finally leaving. The next week she reported her lateness record. It reflected extreme fluctuations, from 7 minutes late to 30 and 40 minutes late. The two times she was very late, she admitted not fulfilling the condition of going back inside the house and waiting the same amount of time she was late. I instructed her to fulfill the condition no matter how late she would be. "I cannot ask you to do what you *cannot* do, but if you want to improve I will ask you to do what you may not *want* to do". Two weeks later she reported much improvement—getting out of the house on the average of 11 minutes late, with no extreme late days and several days on time.

CASE #3:

An 18–year–old Orthodox Jewish yeshiva student (Bonchek & Greenberg, in press) had extreme difficulty praying. He would compulsively repeat words, often waiting long minutes before being able to gets words out, during the waiting time he would focus on gaining the concentration necessary for prayer. His total praying time was much longer than that of his fellow students. After recording his prayer time and the number of repetitions, we considered an appropriate intervention. In this case, EX/RP was not applicable because it would be impossible to prevent the rapid repetition of words—it happened almost instantaneously. His long

pauses were not behaviors, so that Response Prevention could not be applied, since there was no response to prevent. The EX/RR intervention was used. He was told that if he repeated words he would have to go back to the beginning of the prayer and start all over. He protested adamantly: "If I repeat the prayer I will be saying God's name in vain. I am not allowed to do that." He was told that religious teachers of young children often repeat God's name in their instructions to the children. Since he, too, was relearning to pray correctly, repetition would be permitted. He then consented to comply with our instructions. Almost immediately he showed a sharp reduction in repetitions in his prayers (from an average of 70 to an average of five), as a consequence his prayer time speeded up. Treatment lasted three months, three times a week. By the end of three months of treatment with EX/RR his prayers were nearly normal. His speed was within normal time parameters, though he still evidenced some tension while praying. Both at a three–month and at a three–year follow up his praying behavior remained normal with no indication of tension.

STRATEGIC THERAPY & EX/RR

For the EX/RR technique to be effective it must be integrated into an overall Strategic/Behavioral therapeutic approach. Because of the counterintuitive nature of this technique (telling the patient to do *more* of what he wants to do *less* of), it would not be acceptable to the patient were he not psychologically primed to accept it. Therefore, if the technique were simply added to the CBT therapist's armamentarium as another behavioral technique, it would almost certainly fail. The patient would adamantly refuse to comply. It would make no sense to him; he came to therapy to be helped to *stop* repeating compulsively, now he is told to *repeat* his compulsive behavior even more!

When we compare EX/RP with EX/RR, we see that Response Prevention is a technique that makes sense to the patient (he wants to be able to *prevent* his compulsive response) but is one that may be difficult for him to do; sometimes it is "impossible" to comply with the instruction. Response Repetition, on the other hand, is a technique that makes no sense to the patient (he came to therapy to get rid of his repetitions and now he is being told to repeat even more) but one he can easily comply with—if he agrees to do so!

With this in mind, the strategic therapist realizes that his sights have to be focused on prepping the patient to comply with the Response Repetition assignment once it is given. This must be at the forefront of the therapist's plan from the very first therapeutic encounter and every

maneuver must be geared towards that end. In anticipation of its use, the therapeutic alliance must transmit certain strategic messages. These are:

1) A Positive, Nonconfrontational Style

The therapist "speaks the patient's language" (Nardone & Watzlawick, 2005, p. 68). This means that the therapist uses the patient's words and terminology, instead of having the patient learn the therapist's terminology (e.g. resistance, denial, compulsion, extinction etc.). It also means that the therapist views the problem as the patient does—not so much as a problem, but as a need. Compulsive cleanliness, for example, is reframed as a positive hygienic trait, but perhaps with a goal that might be reached even more efficiently if the operation were slightly altered. In this way, the patient is not thrust into a confrontational posture *vis a vis* his therapist. Part of this approach is to emphasize the positive and de-emphasize the less positive. We focus on any achievements gained since the previous session instead of focusing on problems, as is often the case in traditional psychotherapy. The nonconfrontational atmosphere in the sessions is the soil out of which future compliance can flower.[1]

2) The Illusion of Alternatives

The second stratagem is the "illusion of alternatives" (Nardone, 2007). This means that the patient is offered what appears to be a real choice, but in actuality, is not. His choice between alternatives is an illusory one. A real choice pits alternatives against each other that have different outcomes, here both alternatives have the same outcome. By being given the opportunity to choose, the patient's comfort in therapy is enhanced, thus his willingness to comply in the future increases. He feels he is not being forced. Actually, both the alternatives the patient faces are equally good because both "force" him to progress in therapy.

This would mean that the therapist first suggests the EX/RP technique and only later introduces the choice of EX/RR. This is done for two reasons; the first is because of EX/RP's successful track record in treating OCD. If the patent is capable of moving forward with EX/RP, there is no reason not to use it. If, however, he has difficulties with complying, then the therapist expresses empathic understanding of his difficulties and then presents Response Repetition as an alternative. The second reason for suggesting EX/RR only *after* EX/RP had been tried, is that the patient,

[1]Simpson, Zuckoff, et al. (2008) recently reported using similar tactics in Motivational Interviewing (MI) in treating OCD. But there are significant differences between the Strategic/Behavioral and MI, particularly the use of prescribing the symptom.

once having tried what made sense to him (EX/RP), but having failed at it, will be more receptive to the new assignment of repeating his compulsion, even though it may sound strange to him.[2] He is strategically checkmated, faced with the choice of continuing to try (and fail) at EX/RP or giving Response Repetition a try. It is "an offer he can not refuse." It is an illusion of alternatives because *whichever he chooses, his choice will advance him in therapy.* This illusion of alternatives is usually effective in achieving compliance.

It is important to examine this illusion of alternatives closely. What we have here actually is an illusion of alternatives "to the second power." The patient first chooses between EX/RP and EX/RR; whichever one he chooses will advance him in therapy. Then if he chooses EX/RR, he is again faced with two alternatives. Either he can stop ritualizing all together or he can ritualize "to his heart's content" but then he will have to repeat it even more than he wants to. Note that both of these latter choices will also advance him in therapy. The beauty of this stratagem is best grasped when compared to CBT's way of handling noncompliance. Cognitive Behavioral Therapy offers the noncompliant patient two real (not illusory) alternatives—either to continue in therapy doing something he finds difficult to do or dropping out of therapy. This is a real choice between win or lose. Strategic/Behavioral Treatment on the other hand, offers an illusory choice; one that is between win and win.

3) Say Little and have the Patient do a Lot

This means the therapist does not get involved in discussions with the patient explaining the purpose or rationale of the particular technique. To the patient's questions he offers a Sphinx–like response. "I can not explain it to you now. First we must try it. I will explain everything by the end of the therapy." Getting dragged into explanations only diverts the therapist's efforts and weakens the technique's effectiveness. This is true for most therapeutic applications, because if we make ourselves dependent on the patient's understanding in order to achieve his compliance, we remain dependent upon him, until he says: "I no longer understand, so let's stop." And if this is true for therapy in general, it is doubly true for discussions

[2]This is a prime example of the strategic method. The therapist strategically considers how the patient may respond to his first therapeutic suggestion and *takes into account at the very beginning what his next step will be should the patient refuse his suggestion.* That is the therapist realizes that the patient may refuse EX/RP and has already planned his strategy at the outset. If he refuses, the therapist will then introduce—only after his refusal (or failure)—the EX/RR option.

with obsessive individuals. These discussions become "sticky" and they will never let up.

It is therapeutically healthy to have some mystery in the methods used. When everything is understood, everything becomes negotiable. This "do–as–I–say–and–I'll–explain–everything–later" strategy is a central feature of Strategic/Behavior therapy (SBT). It stands in stark contrast to the CBT therapist's eagerness to educate his patient every step of the way. SBT, on the other hand, takes the approach of respecting the patient's individuality while at the same time realizing that his rational thinking is under the influence of his compulsive predicament. Should the therapist offer a reasoned explanation it may be used by the patient, albeit unwittingly, to avoid working on his problem. We help him by keeping all such discussions off limits for the time being.

These three stratagems are necessary components of the therapeutic application of the Response Repetition technique. Its success is as dependent on patient compliance as it is on the inherent power of the technique itself.

Below is a Table, which compares and contrasts the characteristics of the three therapeutic models.

DISCUSSION

I now address the question: By what psychological means does EX/RR relieve OCD symptoms? The effectiveness of Response Prevention has been understood to be based on emotional habituation. This means that once the individual experiences the anxiety propelled by his obsession (Exposure) but does not relieve the anxiety by ritualizing compulsively (Response Prevention) the anxiety eventually habituates and extinguishes. The person no longer feels anxious when he is exposed to a compulsive trigger and thus will have no need to ritualize.

Table 1. CHARACTERISTICS OF THREE TREATMENT MODELS FOR OCD

	CBT	CT*	SBT
Patient compliance	Moderate	Good	Very good
Therapist's presence**	Necessary	Not necessary	Not necessary
Patient capable of doing assignments	Difficult	Not easy	Not difficult
Effectiveness	50%–60%	Tested, but unproven	Untested

*CT without EX/RP
**for optimal results

But the explanation for Response Repetition's effectiveness must be different, because with this technique the patient does not experience prolonged anxiety nor is it habituated. The anxiety is not experienced in RR because the individual is allowed, even encouraged, to ritualize, which relieves his anxiety. For the same reason it is not habituated. The anxiety is not allowed to be experienced without relief. An explanation must rest elsewhere.

Strategic theorists explain the underlying psycho–logic as follows. Compulsive rituals are, by definition, repetitions done against one's will. Conversely, *prescribed* rituals (when carried out as prescribed) are in accordance of one's will, and therefore, are not symptoms. By following the prescription, the patient turns an uncontrolled behavior (a symptom) into a behavior now under his control (and thus not a symptom). Once the behavior is under the patient's control, he can then turn it off, just as he was able to turn it on. The metaphor used is that if one can turn a faucet on (increasing the symptom's frequency), he can likewise turn it off (control and eliminate the compulsive symptom's frequency).

Another possible explanation may be the psychological process of satiation (an enjoyable behavior performed "more than enough" times loses its enjoyable affect). In fact, the behavior becomes a punishing event. Once the compulsion becomes an unpleasant behavior (and not an anxiety–relieving one) the patient willingly drops it. Ayllon and Michael's (1959) classic study is an example of this. They treated a hospitalized patient who hoarded towels. She kept about 60 towels in her small room at any one time. They decided to sate her with towels; every day nurses would bring here more and more towels until she had accumulated nearly 600 (!) towels in her room. She begged to have them taken away and she began removing them. Months later she was down to one to two towels a week in her room. Maybe our patients were "sated" with their ritual and gave it up.

Yet another explanation may be the effects of "negative practice." Dunlap (1942) investigated the effects of repeating unwanted behavior innumerable times. He found that when patients carried out such "negative practice," the unwanted behavior eventually was extinguished.

These explanations do not clarify Rabavilas, Boulougouris and Stefanis' (1977) surprising finding that *not one* of their patients with checking compulsives was willing to repeat his compulsion and thus stopped checking all together. Clinical experience may offer the best explanation. Patients, when told to repeat the compulsion even after they no longer feel the need to, often asked: "Is this a punishment?" Clearly, in their minds,

they were being punished for performing the ritual; their punishment is to repeat it. (To reduce resistance the therapist denies this is a punishment. His explanation is that this is a relearning experience; just as a math teacher requires a failing student to do more problems in order to learn how to solve them correctly.)

This patient's gut feeling that this is punishment is a simple explanation, which rings true. Remember that the term "punishment" here is descriptive term not a moral one. According to learning theory, any event that follows a behavior and weakens it, *i.e.,* lessens its frequency, is considered a "punishment." The person is not being "punished" for his "bad" behavior, obviously. The term reflects a law of learning that any consequence, which lessens the frequency of his compulsion, is by definition a punishment. This means that if RR lessens the frequency of the compulsion it is a punishment. In this way, it breaks the compulsive habit by punishing it. The elegance of this punishment is that the patient applies it to himself by doing what he ostensibly wants to do—ritualize.

These cases, though anecdotal, show the surprisingly powerful therapeutic effects of Exposure and Response Repetition (EX/RR). They point the way to more controlled research on this Strategic/Behavioral technique for dealing with OCD rituals, particularly those that cannot be dealt with EX/RP.

RESEARCH SUGGESTIONS

Strategic/Behavioral treatment of OCD has not been tested in a rigorous research design. It would be most fitting to do a pilot test. Here a specific type of OCD symptoms can be chosen (for example compulsive checking or washing). Two groups of patients equated along significant variables would be assessed and treated. One group would receive the regular EX/RP treatment; the other group will receive EX/RP, and those unable to complete this treatment will then be offered EX/RR. Dependent variables will be how many patients drop out of treatment and the percent of recovery or improvement. All those treating the patients must be familiar with CBT, and the second group of therapists must be familiar with the Strategic treatment as well.

SUMMARY

In this article, I analyzed the CBT technique of choice for OCD, Exposure and Response Prevention as well as Cognitive therapy without EX/RP, and pointed out certain limitations and the reasons for them. I examined the issue of patient noncompliance and illustrated the Strategic/

Behavioral approach and the new technique of Exposure/Response Repetition, which effectively deals with it and thus, overcomes the limitations of EX/RP. Suggestions for research for further exploration of this intriguing approach are suggested.

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