Jonathan S. Abramowitz
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Advances in Psychotherapy –
Evidence-Based Practice

Obsessive-Compulsive Disorder in Adults

2nd edition

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Dedication

To our parents: Ferne and Leslie Abramowitz; Doug and Jennie Jacoby.

Acknowledgments

We are indebted to a large group of people, including series editor Danny Wedding and Robert Dimbleby of Hogrefe, for their invaluable guidance and suggestions. The pages of this book echo with the clinical wisdom we have acquired through direct and indirect learning from masters of the science and art of psychological theory and intervention, including Joanna Arch, Donald Baucom, David A. Clark, Michelle Craske, Edna Foa, Martin Franklin, Michael Kozak, Jack Rachman, Paul Salkovskis, and Michael Twohig.

We dedicate this book to our clients and research participants who come to us seeking help and, in the face of uncertainty, find the courage to approach what they fear and give up their compulsive behaviors so that they can achieve a better quality of life. They believe in us, confide in us, challenge us, and educate us.

Contents

Preface

This book describes the conceptualization, assessment, and psychological treatment of *obsessive-compulsive disorder* (OCD) in adults, using empirically supported *cognitive behavior therapy* (CBT) interventions. The centerpiece of this approach is *exposure and response prevention* (ERP), a well-studied tandem of CBT techniques derived from learning theory accounts of OCD. The delivery of ERP is also informed by the fields of cognitive therapy, *acceptance and commitment therapy* (ACT), couples therapy, and inhibitory learning. We assume the reader will have basic knowledge and training in the delivery of psychotherapeutic interventions, yet not necessarily be a specialist in OCD. This book is for mental health professionals and trainees wishing to learn therapeutic strategies for managing OCD effectively in day-to-day clinical practice.

The book is divided into five chapters. The first describes the clinical phenomenon of OCD differentiating it from other problems with similar characteristics and outlining scientifically based diagnostic and assessment procedures. Chapter 2 reviews leading theoretical approaches to the development and maintenance of OCD, and their treatment implications. In Chapter 3, we present a framework for conducting an initial assessment of OCD and for deciding whether a particular client is a candidate for the treatment program in this volume. Methods for explaining the diagnosis of OCD and introducing the treatment program to clients are incorporated. Chapter 4 presents the details of how to conduct effective ERP for OCD. There are numerous case examples and transcripts of in-session dialogs to illustrate the treatment procedures. All case examples are based on composites of clients and our clinical experiences but do not represent any specific individual. The chapter also reviews the scientific evidence for the efficacy of this program and discusses how to identify and surmount a number of common obstacles to successful outcomes. Finally, Chapter 5 includes a series of case examples describing the treatment of various sorts of OCD symptoms (contamination concerns, fears of responsibility for harm, etc.). A variety of forms and client handouts for use in treatment appear in the book's Appendix.

OCD is a highly heterogeneous problem. Some clients experience fears of germs and contamination, while others have recurring, unwanted anxiety-evoking ideas of acting in ways that are wholly inconsistent with their values or character (e.g., using racial slurs or deliberately running into pedestrians while driving). Still others experience senseless but distressing doubts about unsolvable or existential questions (e.g., "how do I know I'm really in love," "what if my existence is just a dream?"). It is rare to see two individuals with completely overlapping symptoms. Thus, we provide a multicomponent approach that guides the clinician in structuring treatment to meet individual clients' needs. In this book you will find practical clinical information and illustrations, along with supporting didactic materials for both you and your clients.

discomfort in specific body parts (e.g., face) or a diffuse psychological distress or tension (e.g., "in my head"). This sensory discomfort is then relieved by motor responses (e.g., head twitching, eye blinking). (More details regarding differential diagnosis of OCD vs. tics/Tourette's disorder are reviewed in Section 1.5.3)

1.2.4 OCD From an Interpersonal Perspective

OCD commonly has an interpersonal component

The previous description highlights the experience of OCD from the individual's perspective. Yet OCD commonly has an interpersonal component that may negatively impact close relationships, such as that with a parent, sibling, spouse, or romantic partner (Abramowitz et al., 2013). This component may be manifested in two ways. First, a partner or spouse (or other close friend or relative) might inadvertently be drawn to help with or accommodate the performing of compulsive rituals and avoidance behavior out of a desire to show care or concern for the individual with OCD (e.g., to help reduce anxiety). Second, OCD symptoms may lead to arguments and other forms of conflict within these relationships.

Symptom Accommodation

Accommodation occurs when a loved one (a) participates in the client's rituals (e.g., answers reassurance-seeking questions, performs cleaning and checking behaviors for the client), (b) helps with avoidance strategies (e.g., avoids places deemed "contaminated" by the client), or (c) helps to resolve or minimize problems that have resulted from the client's OCD symptoms (e.g. making excuses for the person's behavior, supplying money for special soaps). Accommodation might occur at the request (or demand) of the individual with OCD or it might be voluntary and based on the desire to show care and concern by reducing the distress of the individual with OCD. The following vignette illustrates accommodation:

> Avery adores her dog, Sadie, a gentle golden retriever who has been her loyal companion for years. Recently, Avery has been plagued by intrusive thoughts of accidentally harming Sadie. These thoughts terrify her, leading her to avoid activities like cooking, where she fears a knife might slip and hurt Sadie. She refuses to watch movies or shows that depict violence and insists on rearranging her furniture to avoid any accidental collisions that could harm her pet. Avery's partner, Cameron, does everything possible to ensure that sharp objects are safely stored away, avoids discussing any potentially upsetting topics related to pets, and even rearranges their daily routines to minimize any perceived risks to Sadie. Cameron reassures Avery constantly, reminding her that he would do anything to protect both her and their beloved dog. Despite Cameron's loving support, Avery's obsessive fears continue to cause her significant distress, making everyday tasks and interactions challenging as she strives to keep Sadie safe from harm.

assessment to determine whether a clinical diagnosis of OCD is appropriate. The OCI-4 is freely available on the Internet at https://static1.squarespace.com/static/56d5ca187da24ffed7378b40/t/61de37dfa41a455c016192b0/1641953248179/OCI4+FORM.pdf.

1.7.2 Structured Diagnostic Interviews

Several structured diagnostic interviews that are based on DSM-5-TR criteria can be used to confirm the diagnosis of OCD: the *Anxiety and Related Disorders Interview Schedule for DSM-5* (ADIS-5; Brown & Barlow, 2014), the *Structured Clinical Interview for DSM-5* (SCID; First et al., 2015), the *Diagnostic Interview for Anxiety Mood and OCD-Related Neuropsychiatric Disorders* (DIAMOND; Tolin et al., 2018), and the *Mini International Neuropsychiatric Interview* (MINI; Sheehan et al., 1998). Each of these instruments possess good reliability and validity. The DIAMOND is freely available over the Internet (https://giving.hartfordhospital.org/tolin-diamond-training-video/), and the other measures are available for purchase (ADIS: Oxford University Press; SCID: American Psychiatric Association; MINI: https://harmresearch.org/mini-international-neuropsychiatric-interview-mini/).

1.7.3 Semistructured Symptom Interviews

OCD is unique among the psychological disorders in that the form and content of its symptoms can vary widely from one person to the next. In fact, two individuals with OCD might present with completely nonoverlapping symptoms. Such heterogeneity necessitates a thorough assessment of the *topography* of the individual's symptoms: what types of obsessions and compulsions are present, and how severe are these symptoms?

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

The Y-BOCS is a measure of OCD symptom severity

The *Yale-Brown Obsessive Compulsive Scale* (Y-BOCS; Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989), which includes a symptom checklist and a severity rating scale, is ideal for addressing these questions. Between 30 and 60 minutes might be required to administer this semistructured interview. The first part of the symptom checklist provides definitions and examples of obsessions and compulsions that the clinician reads to the client. Next, the clinician reviews a comprehensive list of over 50 common obsessions and compulsions, and asks the client whether each symptom is currently present or has occurred in the past. Finally, the most prominent obsessions, compulsions, and OCD-related avoidance behaviors are listed. A benefit of this checklist is it can encourage clients who would be reluctant to spontaneously share unacceptable thoughts (e.g., about violence or sex) to come forward with these symptoms once prompted about them on the checklist (i.e., normalizing these obsessional thoughts as common).

Table 2
Summary of Maintenance Processes in OCD

Maintenance process	Description
Selective attention	Hypervigilance for threat cues enhances the detection of obsessional stimuli.
Physiological factors	The fight-or-flight response is a normal response to perceived threat. Emotional reasoning reaffirms mistaken beliefs that lead to feeling anxious.
Anxiety-reduction behaviors	Overt and covert rituals, reassurance seeking, and neutralizing strategies are reinforced by the immediate reduction in distress they engender. In the long-term, these strategies prevent disconfirmation of mistaken beliefs, because of how their outcomes are incorrectly interpreted.
Passive avoidance	Avoidance produces temporary anxiety reduction but prevents disconfirmation of overestimates of risk, because the person never has the opportunity to find out that the danger is unlikely.
Concealment of obsessions	Hiding obsessions from others prevents disconfirmation of mistaken beliefs about the normalcy of intrusive thoughts.
Attempted thought control	Attempts to control or suppress unwanted thoughts lead to an increase in unwanted thoughts. Misappraisal of thought control failure leads to further distress.
Experiential avoidance	The tendency to evade or escape unpleasant thoughts, feelings, or body sensations, even when doing so interferes with one's functioning (i.e., psychological inflexibility).

Table 3
Domains of Pathogenic Beliefs in OCD

Belief	Description
Inflated responsibility and overestimation of threat	Belief that one has the power to cause and/or the duty to prevent negative outcomes featured in intrusive thoughts. Belief that negative events associated with intrusive thoughts are likely and would be insufferable.
Exaggeration of the importance of thoughts and need to control thoughts	Belief that the mere presence of a thought indicates that the thought is significant. Belief that complete control over one's thoughts is both necessary and possible.
Perfectionism and intolerance of uncertainty	Belief that mistakes and imperfection are intolerable. Belief that it is necessary and possible to be 100% certain that negative outcomes will not occur.

3.2 The Diagnostic Assessment

How to conduct a diagnostic assessment for OCD

The *diagnostic interview* begins with the client providing a general description of their problem, and the effects on functioning and quality of life, as well as the reasons for seeking help. Be sure to ascertain the functional relationship between obsessions and rituals as described in Section 3.1. Also, assess the onset and historical course of the problem; social, developmental, and medical history; cultural and familial factors that might impact OCD; personal and family history of psychiatric treatment; substance use patterns (i.e., alcohol, marijuana, tobacco, and other recreational drugs); and exercise and sleep habits. In addition, assess the treatment history (particularly treatment for OCD) as this may influence your current recommendations. Once this information has been obtained, use the Y-BOCS, BABS, and DOCS to gather additional severity data.

Three additional self-report instruments, the *Obsessional Beliefs Questionnaire* (OBQ), *Interpretations of Intrusions Inventory* (III; Obsessive Compulsive Cognitions Working Group, 2005), and the *Acceptance and Action Questionnaire for OCD* (AAQ-OCD; Jacoby et al., 2018) can be administered to assess OCD-related dysfunctional beliefs and experiential avoidance (i.e., those described in Table 3). The OBQ and III are reprinted in the edited volume by Frost and Steketee (2002) on cognitive aspects of OCD, and the AAQ-OCD can be found online (http://www.jabramowitz.com/ocd-aaq.html).

Clinical Pearl

When Clients Report Obsessions or Compulsions in Isolation

Whereas the majority of clients with OCD readily describe obsessional fears and compulsive rituals, some present with complaints of "pure obsessions" or "compulsions without obsessions." When assessing such clients, keep in mind that more than 90% of people with OCD report both obsessions and compulsions. Thus, you might need to conduct a more in-depth functional analysis. For individuals reporting only obsessions, this means inquiring about the use of any anxiety-reduction strategies (mental rituals or subtle behavioral or cognitive neutralizing or avoidance) that might be functioning to maintain obsessional fear. Most clients do not recognize subtle safety behaviors as OCD symptoms, or might confuse mental rituals and obsessions, but these mental rituals maintain obsessional fear just as surely as overt rituals. If these phenomena are not present, perhaps the "obsessions" are not intrusive or anxiety-evoking and therefore are not indicative of OCD (e.g., perhaps they are depressive ruminations or worries as in GAD).

When clients describe compulsive behaviors but fail to define obsessional fear, inquire about what triggers these behaviors. Sometimes clients will lead by describing problematic behaviors like checking the stove is turned off, for example, and only after probing will share that these behaviors are driven by the fear of their home burning down. If compulsions are not evoked by specific intrusive or distressing thoughts or situations as described in Chapter 1, however, OCD might not be the correct diagnosis. Perhaps an impulse-control (e.g., trichotillomania) or tic disorder is present. You can use the Y-BOCS checklist, self-report questionnaires, and detailed inquiry regarding the functional aspects of reported symptoms to rule in or rule out the diagnosis of OCD.

4

Treatment

4.1 Methods of Treatment

The "nuts and bolts" of conducting ERP

This chapter presents the fundamentals of how to plan and implement ERP for OCD. Box 3 shows a suggested agenda for what is to be accomplished in each treatment session, although flexibility is encouraged to adapt to the unique needs and progress of each client. Treatment might be delivered in once-weekly, twice-weekly, or even daily sessions depending on symptom severity and access issues (e.g., clients traveling from out of town might receive five daily sessions for 3 consecutive weeks).

Box 3 **Suggested Session Structure in ERP for OCD**
Session 1
• Begin functional assessment of OCD symptoms • Introduce self-monitoring • Begin psychoeducation
Session 2
• Continue functional assessment • Psychoeducation • Informal cognitive therapy • Begin planning for exposure and generating the exposure list
Session 3
• Psychoeducation • Informal cognitive therapy • Finalize and agree on the exposure treatment plan
Sessions 4–14
• Exposure • Response prevention • Informal cognitive therapy
Sessions 15 & 16
• Final exposures • Relapse prevention • Wrapping up exposure and response prevention • Assess outcome

Clients may point out that although everyone has intrusive thoughts, their own intrusions are more frequent, more distressing, and more intense compared with those of people without OCD. This may be true, and it is therefore important for them to understand the role of thinking patterns (which they can learn to change) in causing normal intrusive thoughts to escalate into highly distressing and recurrent obsessions, as is discussed in the next section.

Role of Dysfunctional Thoughts and Beliefs in OCD

Helping the client understand the relationship between thoughts and emotions

At the heart of ERP is the idea that our emotions and behaviors are largely determined by our *thoughts and beliefs* about situations, not by the situations themselves. Accordingly, it is helpful for clients to understand the process by which their own mistaken thoughts and beliefs lead to emotional responses such as anxiety, which in turn, exacerbates obsessional thinking.

For example, when someone with obsessions about germs drops an object on the floor and then picks it up, the following dysfunctional (i.e., exaggerated, mistaken, or rigid) thoughts and beliefs might be activated: "Floors have lots of dangerous germs," "I am highly susceptible to illness", "I could get very sick", and "I've got be completely certain that I won't get sick." These cognitions evoke distress and the urge to ritualize (i.e., washing and cleaning).

Clinical Vignette 1 illustrates the use of a Socratic dialog in which the therapist helps the client understand how their thinking dictates their emotional and behavioral responses.

Clinical Vignette 1
Illustration of the Cognitive Model With Non-OCD-Relevant Situation

Therapist:	Suppose you and a friend plan to meet for dinner at 7:00 p.m., and it is now 7:30 p.m. and your friend hasn't shown up or even called to say that she'll be late. If you conclude that your friend decided that you are no fun to be with, how will you feel?
Client:	Sad or depressed.
Therapist:	Right. How about if you believed your friend was being late on purpose and was being inconsiderate of your time?
Client:	Then I'd feel angry.
Therapist:	Sure. How about if you thought that your friend had been in a terrible accident?
Client:	I'd be worried.
Therapist:	Exactly. Do you see the importance of your thinking?
Client:	Yes. Depending on how I interpret the same situation, I could feel different emotions.
Therapist:	That's right. The way you think about situations influences your emotional responses. So, *you*, not situations, have control over your emotions. This is called the cognitive model of emotions.

After illustrating this model using a situation that is not emotionally charged for the client, the next step is to apply it to an OCD-relevant situation (Clinical Vignette 2). The client in the example had an excessive fear that she would catch the herpes virus from a particular coworker who once had a cold sore on her lip.

4.4.3 Involving Significant Others in Treatment

As has already been mentioned, for clients involved in close relationships (e.g., who are married), involving a significant other in ERP can have benefits; especially if the client is having difficulty completing exposure practices independently. The partner should attend treatment sessions and be introduced to the treatment approach and taught how to assist with exposure exercises by serving as a coach. This role includes offering emotional support to the client and providing gentle, but firm reminders not to ritualize. Train the partner to ensure that fears are adequately tested, and rituals resisted, during exposures. Emphasize helping the client get through the obsessional anxiety, as opposed to the partner trying to alleviate this distress.

There are four phases of partner-assisted exposure

In their couple-based CBT program for OCD, Abramowitz and colleagues (2013) divide the process of partner-assisted exposure into four phases and incorporate communication skills in each phase to help couples complete the exercises as a team. In session with the couple, you can introduce the four phases and then work through an exposure practice as follows:

Phase 1: Discussing the Exposure Task

Begin by helping the client and partner clarify the specifics of the exposure task. Both parties are encouraged to discuss how each is feeling about the upcoming practice (e.g., what is the client with OCD most worried about) and to identify potential obstacles. The client is helped to specify how they would like the partner to help with the exercise.

Phase 2: Approaching the Feared Situation

The second phase involves approaching and engaging with the exposure item. Encourage the client to express their feelings to the partner, who listens carefully and reflects these feelings instead of offering advice or solutions (e.g., "I can tell that you're feeling anxious about this exposure. I know this is challenging"). If the client becomes anxious, the partner acknowledges this, empathizes with the distress, and uses praise to reinforce the client's hard work (e.g., "You're doing great. I'm really proud of you!"). The partner continues to compliment the client on handling the situation throughout the exercise and avoids making negative statements. The partner also resists the temptation to distract the client, provide reassurance, or use any other anxiety reduction strategies.

Phase 3: Dealing With Intense Anxiety

If the client experiences intense distress during exposure, they are to communicate this to their partner. In turn, the partner acknowledges that exposure is challenging but that the client can get through it. If the client absolutely cannot continue with the exposure, a brief timeout can be taken during which the partner provides support in ways the client would like (but *not* using reassurance, rituals, or accommodation behaviors, if possible). The two parties also discuss what went wrong and how they can approach resuming the exposure. If the client with OCD decides to stop, ultimately it is their decision (e.g.,

of disagreements over whether an exercise is "safe" (and it is more likely to result in the client being willing to do the exercise vs. you having to convince them).

Clinical Pearl
When the Client Argues

When a client becomes argumentative (e.g., during exposure), it might indicate a rising level of distress. Instead of engaging in arguments about risk or "what is normal," the best strategy is to identify the problem and ask the client what they might suggest for resolving it. Have in mind how much it is useful to modify the therapy instructions without compromising treatment. Statements such as the following might also be helpful:

- You are here in treatment for yourself – not for me. So, I won't argue or debate with you. Doing the treatment is entirely your choice. You stand to get better by trying these exercises and learning how to handle the anxiety. But you are also the one who has to live with the OCD symptoms if you choose not to do the therapy or change it from what I'm suggesting. I'm here to help you get back to the life that you want.
- Remember that we both agreed on the treatment plan. I am here to help guide you, but to see improvements you will also need to put the work in too.
- I agree with you that there is *some* risk involved. The goal of treatment is to help you learn that you can be OK even in situations where it is impossible to have a complete guarantee of safety.
- I realize ***most*** people wouldn't go out of their way to do what I am asking you to do. But the therapy isn't about what people *usually* do. These tasks are designed to help you learn to manage acceptable levels of risk and uncertainty and to manage your OCD. Going above and beyond what people usually do is sometimes the most effective way to get over OCD (and I know you can do it!).
- Ultimately the decision is up to you, and I know this is a difficult one. Yet, if you are going to get over OCD, you have to confront uncertainty and find out that you can manage the risk.

4.5.4 Persistent Family Accommodation of OCD Symptoms

Accommodation can hinder treatment outcome

Accommodation of OCD symptoms by an intimate partner, other relative, or friend can hinder treatment outcome. If this is occurring, work with the client and accommodating individual together to help them change these interaction patterns. Describe accommodation and its deleterious effects, noting that such behavior is often well intended (as we discuss earlier in this book; see Section 1.2.4). Then, help the parties choose an activity which has become hampered by OCD symptoms, and facilitate a discussion about ways to handle this situation by promoting the idea of exposure and anxiety acceptance, rather than relying on avoidance and compulsive rituals. In other words, help the parties build ERP techniques into their relationship. For example, a husband might resume using various rooms in the house that had been off-limits. A wife might stop checking doors and windows prior to coming to bed. The

Case 3: Relationship OCD

Stephanie, a 28-year-old woman who lived with her fiancé, Andrew, experienced debilitating doubts about her romantic relationship. These intrusions would often pop up when the two of them were spending quality time together (e.g., watching a TV show or having dinner with friends). Specifically, Stephanie would find herself starting to wonder: "Do I love Andrew?" "Is he the right person for me?" While she was fairly certain that she wanted to marry Andrew (and thus said yes when he proposed), she still struggled with lingering doubts about what if she'd made a mistake and if she was really ready to spend the rest of her life with him. Stephanie also engaged in time-consuming rituals such as testing herself to see if she was still as attracted to Andrew as she once was, by scrolling back in her phone to look at old photos from their first dates and mentally reviewing the details to see if doing so sparked the same emotions that the original moments once did. Many of Stephanie's other friends were getting married and committing to their long-term partners, and she wondered what was wrong with her that in comparison they all seemed so sure. Andrew was unaware that Stephanie was experiencing these obsessional thoughts. He had noticed recently that she had been avoiding being sexually intimate, but he attributed that to the stress of the wedding planning. And as the wedding approached, Stephanie presented to treatment because the doubts about how to move forward were escalating to the point that they were interfering at work and with her sleep. She lived in a rural part of her state, and so finding an ERP therapist within a 1-hr radius of her home was not possible. Thus, Stephanie conducted the following course of ERP solely over a secure telehealth platform.

Table 10
Stephanie's Exposure List (With SUDS)

Item	SUDS
Watch movie clips of happy couples without comparing my relationship with that in the story	40
Look at photos of us without testing myself to see if I feel the same	55
Being sexually intimate with Andrew without overanalyzing whether I am enjoying it	67
Watching movie scenes or listening to songs about breakups	75
Make final decisions in wedding preparations (e.g., commit to the caterer)	75
Write an imaginal exposure script in which I stay with Andrew and never know for sure if he's the right person	80
Write an imaginal exposure script in which I leave Andrew and never know for sure if I made a mistake	85

Note. SUDS = subjective units of distress.

8

Appendix: Tools and Resources

The following materials for your book can be downloaded free of charge once you register on the Hogrefe website.

Appendix 1: Functional Assessment of OCD Symptoms
Appendix 2: Self-Monitoring of OCD Rituals
Appendix 3: Everyone Has Intrusive Thoughts
Appendix 4: Goal Setting in ERP Worksheet
Appendix 5: Exposure List
Appendix 6: Guidelines for Conducting Exposure
Appendix 7: Exposure Practice Form
Appendix 8: Guidelines for Conducting Imaginal Exposure
Appendix 9: Guidelines for Conducting Response Prevention
Appendix 10: ERP Therapy Summary

How to proceed:

1. Go to www.hgf.io/media and create a user account. If you already have one, please log in.
2. Go to **My supplementary materials** in your account dashboard and enter the code below. You will automatically be redirected to the download area, where you can access and download the supplementary materials.

To make sure you have permanent direct access to all the materials, we recommend that you download them and save them on your computer.

Peer Commentaries

This thoroughly updated second edition offers mental health professionals a clear, concise, evidence-based roadmap for treating OCD in adults. By blending exposure and response prevention with fresh insights from cognitive therapy, ACT, couples therapy, and inhibitory learning, it empowers clinicians to deliver care that is both compassionate and uniquely suited to each client. Rich with expanded clinical guidance, practical tools, and new illustrative case examples, this book stands out as a practical companion for any therapist or trainee seeking confidence and expertise in managing OCD using the latest advances in cognitive behavioral approaches.

Reid Wilson, PhD, Founder and Director, anxieties.com; Author, *Stopping the Noise in Your Head*

Drs. Abramowitz and Jacoby, leaders in the field of OCD, have successfully crafted a user-friendly text for mental health professionals that discusses the nature of OCD, and its evidence-based assessment and treatment. Best practice approaches for assessment and treatment are thoughtfully conveyed with case examples that bring the material to life. This book will be a game changer for those who want to develop their expertise in working with individuals with OCD.

Eric Storch, PhD, Vice Chair & Head of Psychology, Baylor College of Medicine, Houston, TX

In the OCD specialty world, we are often reminded of how lucky we are as clinicians to work with this population and do so using an approach to treatment that really works. Not only does the research repeatedly confirm the efficacy of cognitive behavioral therapy, but if one understands the mechanisms that allow OCD to cause suffering, then CBT with exposure and response prevention simply makes sense to reduce that suffering. In this second edition of Abramowitz and Jacoby's Obsessive-Compulsive Disorder in Adults*, the authors give a thorough and methodical, yet thankfully easy-to-digest presentation of how CBT with ERP can work in practice. The clinical vignettes and clinical "pearls" scattered throughout the book are especially helpful for understanding the* how*, and not just the what and why of OCD treatment. I found myself not only validated for the way I treat OCD and train others to do so, but motivated to try harder to help patients see how capable they really are of mastering this condition.*

Jon Hershfield, MFT, Director, The Center for OCD and Anxiety at Sheppard Pratt; Author, *When a Family Member Has OCD;* Coauthor, *The Mindfulness Workbook for OCD*