When Exposures Go Wrong: Trouble-Shooting Guidelines for Managing Difficult Scenarios that Arise in Exposure-Based Treatment for Obsessive-Compulsive Disorder

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Cognitive-behavioral therapy (CBT) with exposure and ritual prevention (ERP) is widely accepted as the most effective psychological treatment for obsessive compulsive disorder (OCD). However, the extant literature and treatment manuals cannot fully address all the variations in client presentation, the diversity of ERP tasks, and how to negotiate the inevitable therapeutic challenges that may occur. Within this article, we attempt to address common difficulties encountered by therapists employing exposure-based therapy in areas related to: 1) when clients fail to habituate to their anxiety, 2) when clients misjudge how much anxiety an exposure will actually cause, 3) when incidental exposures happen in session, 4) when mental or covert rituals interfere with treatment, and 5) when clients demonstrate exceptionally high sensitivities to anxiety. The goal of this paper is to bridge the gap between treatment theory and practical implementation issues encountered by therapists providing CBT for OCD.

KEYWORDS: obsessive-compulsive disorder; cognitive-behavior therapy; exposure and response prevention; treatment; psychotherapy

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INTRODUCTION

In 1998 cognitive-behavioral therapy (CBT) with exposure and ritual prevention (ERP)[1] received "well-established" status as a treatment for obsessive-compulsive disorder (OCD) by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1998). Since receiving this distinction, along with several studies indicating the superiority of CBT to psychotropic monotherapy (e.g., Foa et al., 2005), an emphasis has been placed on increasing the dissemination of CBT among practicing clinicians (Chambless, 2002). However, many clinicians, particularly those with limited exposure to clients with OCD, will likely encounter unforeseen treatment challenges (e.g., incidental exposures) that are infrequently discussed in literature. Despite being useful in disseminating and implementing cognitive-behavioral techniques, therapy manuals do not address all of the different scenarios that occur in exposure-based treatment for OCD (Abramowitz, Franklin, & Cahill, 2003). To obtain this information, clinicians must look to clinical consultation and supervision or to a limited body of literature, comprised of theoretical reviews, clinical case studies, and letters to the editor. While clinical consultation is certainly a recommended strategy for clinicians regardless of their training level, it may be of only partial utility given the limited experience many clinicians have treating OCD. In the academic literature, Abramowitz et al. (2003) addressed four issues that may confound CBT for OCD, including failing to provide sufficient psychoeducation to clients about exposure-based therapy, neglecting to address reassurance-seeking behaviors, applying exposure during and after treatment inconsistently, and of implementing ritual prevention during exposures ineffectively. From our experiences in this population, we sought to pick up from this report and highlight the following five additional issues that may affect treatment outcomes in OCD: clients failing to habituate during behavioral exposures, therapists and/or clients misjudging how much anxiety an exposure will actually cause, incidental exposures that unexpectedly increase intensity of the exposure, mental rituals performed by clients that interfere with habituation to anxiety, and clients' high anxiety sensitivity.

Exposure-based treatment has been used successfully with clients with OCD since the 1960s (Meyer, 1966). Exposure and ritual prevention involves exposing an individual to an anxiety provoking stimulus/situation

[1]CBT is the broader term and that its subsequent use encompasses ERP.

and then preventing the person from avoiding or engaging in anxiety-reducing behaviors (compulsions). Simple, elegant, and foundational, ERP remains the crux of CBT for OCD, as the therapy purports to break two associations that maintain symptoms: 1) the association between specific stimuli, situations, or thoughts that engender anxiety, and 2) the experience of ritualistic behaviors that temporarily reduce anxiety (Kozak & Foa, 1997). By breaking the second association, ERP prevents the transient and negative reinforcement individuals experience when they reduce their anxiety through performing compulsive behaviors. Thus, exposure-based OCD treatment disrupts an anxiety-driven obsessive-compulsive cycle that without intervention becomes increasingly problematic and interferes with normal life activities (Eisen et al., 2006; Koran, Thienemann, Davenport, 1996).

The process of encouraging OCD clients to fully experience anxiety without engaging in palliative rituals can be a formidable challenge for both a client and his/her therapist (Abramowitz, Franklin, Zoellner, & DiBernardo, 2002). Exposure results in a habituation of anxiety, that is, through repeatedly confronting their fears, clients experience a decrease in anxiety. In addition, through a process of continual ERP, clients learn that their compulsions are not necessary and only serve to maintain symptoms. Moreover, even though ERP does not directly address obsessive-compulsive cognitions, the client's anticipatory anxiety may lessen as he/she learns through repeated exposure that the fears do not come true and/or are not as overwhelming as they were initially perceived to be (Emmelkamp & Geisselbach, 1981).

Considering the difficulty of facing aversive stimuli directly, clients are exposed to feared stimuli in a gradual manner starting with fears that are easy to placate. In the initial sessions, therapists first socialize clients to CBT by providing direct psychoeducation about what they can expect to experience during treatment, offering information about the nature and etiology of OCD. Once the client demonstrates a sufficient understanding of the therapeutic process, a fear hierarchy is constructed, ranking various anxiety-provoking stimuli/situations (without accompanying ritual engagement) on an ascending scale (usually a scale ranging from 0 to 100, with "0" corresponding to complete relaxation and "100" to the highest level of anxiety imaginable). While creating the fear hierarchy, it may be helpful for therapists to establish anchor points (i.e., either extremely distressing or mundane exposures) to which the client can compare other possible exposures (Abramowitz & Larsen, 2007). Lastly, once a fear hierarchy has been created, exposures are begun, starting with mildly anxiety provoking

exposures and gradually moving on to more distressing situations. Also, therapists should be aware that item rankings on a fear hierarchy are likely to change over time (especially during the course of treatment), so that it is important to update the fear rankings during therapy and to be flexible when approaching exposures with clients. For more information on conducting exposure-based CBT for OCD, we encourage interested clinicians to refer to one of the many published treatment manuals (e.g., Kozak & Foa, 1997; March & Mulle, 1998; Abramowitz, 2006; Piacentini, Langley, & Roblek, 2007).

DIFFICULT SCENARIOS THAT MAY ARISE WHILE CONDUCTING EXPOSURE-BASED TREATMENT FOR OCD

The OCD Expert Consensus Guidelines (1997) strongly recommend that clients with OCD receive CBT alone or together with serotonin reuptake inhibitors (SRIs) as a first line treatment (March, Frances, Carpenter, & Kahn, 1997). Despite this strong endorsement, roughly one fourth of OCD clients either refuse to attempt CBT or choose to terminate treatment prematurely (McDonald, Marks, & Blizard, 1988). While the specific reasons for premature termination differ, some clients may discontinue treatment after behavioral exposures do not go well (Keijsers, Hoogduin, Cees, & Schaap, 1994). By improving clinicians' ability to manage difficult scenarios that arise during CBT for OCD, dropout rates could be significantly reduced, thus allowing more OCD clients to experience the benefits of therapy. Some therapeutic challenges have been discussed by others (e.g., Abramowitz et al., 2003); given this, the present article reviews five issues that occur in therapy but have been minimally discussed in the OCD treatment literature:

1) when clients fail to habituate to their anxiety,
2) when clients misjudge how much anxiety an exposure will actually cause,
3) when incidental exposures happen in session,
4) when mental or covert rituals interfere with treatment, and
5) when clients demonstrate exceptionally high anxiety sensitivity.

Failure to Habituate

While most clients generally experience a reduction in anxiety or distress during the course of an exposure (Stanley & Turner, 1995; Abramowitz, 1996), this is not always the case. In particular, we have observed two problems requiring two differing solutions. The first and more common problem involves clients failing to experience a substantive

decrease in anxiety by the end of a session because an exposure task is not long enough. In our experience, if clients stay with an exposure for a sufficient amount of time, they will eventually feel at least a slight reduction in their overall level of anxiety, which, with greater time, will decrease even further. This is important because even minor reductions in anxiety following behavioral exposures can reduce clients' needs to engage in compulsions (Abramowitz, 2006; Freeston & Ladouceur, 1999). Therefore, to allow clients to profit from CBT for OCD, 90-minute (and sometimes greater) sessions are recommended to increase the likelihood that clients will experience anxiety habituation (Kozak & Foa, 1997). However, if it is not possible to extend therapy sessions for various reasons (e.g., time or insurance constraints), clients may be encouraged to continue with an exposure longer on their own, usually in a vacant therapy room or waiting area until their anxiety decreases to a manageable level. A 50% reduction in subjective units of distress (SUDS) is a general rule of thumb to shoot for when conducting exposure-based therapy for OCD.

For example, in the case of Roberta who had severe contamination fears associated with coming into contact with objects associated with an identified "dirty person," her SUDS failed to decrease at all during the allotted exposure time, so she was instructed to wait in the waiting area with a family member until her anxiety subsided. During this process, to ensure client safety and treatment compliance, a clinical staff member regularly checked on the client to assess her anxiety level and encouraged her to wait until she experienced at least a 50% reduction in anxiety. Roberta stayed with the exposure until it reduced by half before leaving the treatment setting. In the event that a client cannot stay beyond the allotted appointment time, the client may profit from encouragement not to ritualize after leaving the session and from reminders that his or her anxiety will eventually subside. (Franklin et al., 2000).

In addition to encouraging clients to abstain from ritualization, we generally discourage clients from taking other measures (e.g., anxiolytic medication) to reduce their anxiety immediately following an exposure, because these behaviors work against one of the key aims of treatment, which is to break the association between experiencing anxiety and the belief that an activity has to be done to reduce it. Clients may also be instructed to self-monitor their anxiety after the session and to report back to the therapist at the next session on how long it took for their anxiety to decrease after leaving a session without first habituating to their anxiety (Foa, 1984).

Clients may fail to habituate if they become depressed instead of

anxious during an exposure, as it is unlikely that there will be a natural decline in depressive affect through habituation (Foa, 1979). Therefore, if the exposure triggers a depressive affect rather than anxiety, the exposure should be discontinued. Continuing to confront aversive stimuli, thoughts, or situations that trigger depression might adversely impact a client's motivation for treatment and inadvertently engender feelings of helplessness in a client (Steketee, Chambless, & Tran, 2001). Initially, a client's emotional response may not be apparent during an exposure so it is important to assess a client's emotional state frequently during CBT. Since clients whose mood becomes depressed during behavioral exposures often have limited insight into their OCD symptoms (Foa, 1979; Steketee & Shapiro, 1995), a therapist may first attempt milder exposures that will likely be tolerated better and allow clients to experience feelings of mastery as opposed to feelings of helplessness. Additionally, considering the many cognitive distortions that are often present with depression (Beck, Rush, Shaw, & Emery, 1987) and OCD (Wilhelm & Steketee, 2006), it might also be effective to explore and/or challenge cognitive distortions that may be interfering with exposure therapy in the hope that these clients will be better able to engage in therapy once their cognitive distortions have been modified. For clients with moderate to severe depression, sequential medication management may be beneficial (Otsuka et al., 2007). In the case of Chuck, a patient with severe contamination fears associated with coming into contact with chemicals, he became depressed during an exposure in which he was asked to spray a common household cleaner. This was apparent through observing his affect and from monitoring his mood. The exposure was discontinued and then it was processed in the safety of the clinician's office. The client had poor insight and truly believed that he was causing harm to himself and others by spraying the chemical. Cognitive strategies were used to try and soften this dysfunctional belief, but they were not effective in shifting him off of his rigid position. Consequently, it was collaboratively determined that it would be best for the client to first try a pharmacological intervention before undergoing a trial of CBT.

Misjudging How Much Anxiety an Exposure Will Cause

Given the distressing nature of confronting aversive stimuli directly, CBT is generally applied in a systematic and controlled manner that involves gradually exposing clients to aversive stimuli (Abramowitz & Larsen, 2007). While a fear hierarchy is a useful and necessary guide, clients may inaccurately gauge how much anxiety an exposure actually

causes. To varying degrees, clinicians can expect clients to overestimate or underestimate how much anxiety they will experience while confronting items on a fear hierarchy. When a client overestimates how much anxiety an exposure will cause, and subsequently experiences little distress in session, he or she may be encouraged to attempt the next item on the fear hierarchy. If this problem persists, it will require the therapist to explore why the client is overestimating the degree of distress he or she expects to experience during exposure. For example, the client may be avoiding or delaying progress in attempting more anxiety-provoking exposures and/or the client may be engaging in covert rituals. If a reoccurring problem is identified, or if a client responds in highly variable ways to similar exposures (i.e., handling similar exposure tasks easily while experiencing significant difficulty with others), then a therapist might inquire to see if a client is subtly avoiding any part of the exposure or engaging in covert rituals during the exposure task. To illustrate, we discuss the cases of Dave and Linda, both of whom had contamination fears. During a series of exposures involving touching various anxiety-provoking objects (e.g., trash cans, bathroom doors), the therapist observed that in each exposure the client used one hand or the same fingers repeatedly. Both clients reported that they had feelings related to anxiety reduction because at least one hand (or finger) remained clean. These cases highlight the importance of monitoring the client's behavior during exposures and preventing partial ritual engagement. Clinically, this issue was addressed by having the clients repeat the exposures in a manner that eliminated their safety areas (i.e., they touched the feared items with both hands and each finger). Thus, increasing the intensity of exposure tasks by having clients come into contact with aversive stimuli more directly (or by having the clients cross-contaminate themselves or personal possessions) can obviate clients' attempts to lessen the impact of an exposure. Freeston and Ladouceur (1999) describe how some clients can still experience profound cognitive shifts during behavioral exposures and that these clients can benefit from exposure-based CBT for OCD without habituating to anxious feelings. Instead of encouraging these clients to "face their fears" or anxieties, they may be encouraged to "step out of their comfort zone" or try behavioral experiments that challenge their cognitive distortions and limiting misperceptions.

When a client becomes flooded by anxiety as a result of underestimating how much anxiety an exposure will cause, a therapist may perceive that the exposure has gotten out of hand and begin to feel anxious. If a therapist reacts too strongly to a client's fears, he or she could inadver-

tently reinforce these fears (e.g., validating a client's fears). When a client is acutely anxious, it may be beneficial for a therapist to remain calm, collected and to show limited emotion (Chambless & Steketee, 1999). In extreme cases when clients underestimate how much anxiety an exposure will actually cause, they may either ritualize excessively or flee from the exposure. If a client does this, we recommend encouraging them to disrupt or modify their ritual in some way. For example, clients who engage in mental rituals, such as compulsive praying, might be encouraged to leave out a couple of words or "experiment" with delaying their mental rituals. In the case of Nancy, a client who verbally repeated color names to block out intrusive thoughts, we encouraged her to delay verbal rituals during exposures (initially, for short intervals but then for increasing periods of time). Through this process, she was able to reduce significantly the amount of ritualizing she engaged in on daily. In a similar vein, ritualistic washers could be encouraged to change the sequence of their washing (i.e., wash the back of their hands before washing their palms if they usually washed palms first) or to wash imperfectly (i.e., purposely leave the left thumb unwashed). For example, a client who ritualistically washed his left hand before his right hand was encouraged to reverse the sequence.

After experiencing an initial setback in therapy, clients should then be encouraged to gradually re-expose themselves to the feared stimulus in a manner that increases the probability that they will be able to manage their anxiety without ritualizing. Although it may be counterintuitive, when a client flees during an exposure, it may be best to encourage him or her to reattempt the exposure so that the association between the feared stimulus/situation is not reinforced and so that the client is not negatively reinforced for fleeing. During re-exposures the therapist should remain calm and try to convince the client to go to a comfortable place (e.g., office, therapy room) so that he or she may regain composure before attempting another exposure. Because the therapeutic relationship between a client and therapist is an important CBT outcome predictor (Keijsers, Hoogduin, Cas, & Schaap, 1994), it may be helpful to validate the client's personal experiences by commenting on the physical signs of distress and offering the option of going somewhere to talk about it. Once the client's anxiety has leveled, try targeting the client's motivation by reviewing the pros/cons of treatment participation, goals, and approach. In addition, clients who misjudge how much anxiety an exposure may cause may need to be provided additional psychoeducation on CBT for OCD; a therapist may need to reiterate how anxiety usually habituates over time and how individuals become better able to confront aversive stimuli through re-

peated exposures (Abramowitz, Franklin, Zoellner, & DiBernardo, 2002). If the client is unwilling to be re-exposed, it may be necessary to slow the pace of therapy and return to an easier and less traumatic exposure. For example, Austin, who suffers from contamination fears, misjudged how much anxiety it would cause him to touch a cigarette butt. He fled the exposure and washed his hands and refused to be re-exposed. He did, however, agree to repeat an exposure lower on his fear hierarchy and to reattempt the cigarette-butt exposure at a later date. This allowed him to end the session with a feeling of self-mastery as opposed to feelings of failure. In fact, it is advisable to end exposure sessions on a positive note, but after a setback, this requires tact by the therapist. Clients might benefit from a therapist helping them to reframe "failures" into "normal setbacks" and by providing encouragement to keep therapy progressing. Also, depending on the client and the therapeutic relationship, it might be effective for the therapist to use humor to lighten the mood and reconnect with the client (Ortiz, 2000). For example, Austin and his clinician were both able to see the humor in his fleeing the exposure, and to this day they still joke about it. Humor, however, needs to be used with caution and works best in the context of a strong therapeutic relationship.

Incidental Exposures

To increase the generalizability of treatment gains, CBT therapists often conduct exposures outside the clinic setting to challenge clients' obsessions and compulsions in natural settings. However, leaving the comfort of the clinician's office increases the probability of incidental exposures happening during the session. Incidental exposures occur when clients agree to confront one item on a fear hierarchy, but during the course of the exposure there is an inadvertent encounter with a more anxiety-provoking stimulus. Thus, during incidental exposure, clients may feel flooded by anxiety. Incidental exposures can be handled by the therapist staying calm, purposely disrupting, modifying, or delaying client rituals, re-exposing the client to the stimulus/situation when he or she is ready to do so, and actively working on maintaining the client's motivation for treatment. However, if the risk for incidental exposure is high, a therapist might first attempt imaginal exposures in session to prime the client for more intense *in vivo* exposures. Additionally, research suggests that using *in vivo* and imaginal exposures might be an optimal treatment as it allows clinicians increased flexibility for targeting real-life, anxiety-provoking stimuli/situations and anxiety-provoking situations that are

difficult to replicate in session (Abramowitz, 1996). The risk of incidental exposures highlights the importance of planning exposures well.

To illustrate, we describe the case of Jane who had severe contamination fears associated with coming into contact with dirty objects or people—particularly contamination by blood or anything resembling blood. For an exposure, Jane agreed to go outside and touch a dumpster. As she walked to the dumpster, she saw a substance on a stairwell that resembled blood. Upon seeing this substance, she panicked and fled to the restroom to wash her hands compulsively. In this situation, the therapist remained calm and processed the incident with the client in the safety of his office. Jane was gently encouraged to confront the stimulus that triggered her anxiety; this suggestion was initially met with considerable resistance. Cognitive and motivational techniques were used to soften the client's resistance. The client was reminded why she was seeking treatment, which included a discussion of what OCD has done to her life (e.g., taken away her ability to work and live independently). They discussed the benefits that she might reap if she challenged herself by doing the exposure. It is often helpful to remind clients with OCD that they are generally anxious, therefore, they might as well be anxious in a productive way (i.e., in a way that might lead to less anxiety in the future). After some persuasion, Jane agreed to stand next to the fear-inducing red substance and refrain from washing; by the end of the exposure, her anxiety had decreased significantly and she left the session with a self-described feeling of mastery over confronting a difficult exposure. Similarly, John also had contamination fears, but they were associated with germs and coming into contact with bodily fluids. During an exposure that involved touching a toilet seat in a public restroom, John noticed a spot on the seat near his hand that he believed was feces, and he feared that he had come into direct contact with it. John reported that he scanned the seat when he entered the stall area and did not notice this particular spot. After trying to remain in the exposure for about one minute, John reported that he was too distressed to continue with the exposure and he fled the restroom. Once again, the therapist remained calm and processed the incident with the client. John was encouraged to return to the exposure and was reminded of the effects related to fleeing exposures and exacerbation of OCD symptoms. John agreed to return to the restroom, but was reluctant to repeat the exposure. In this situation, the therapist had John touch the toilet seat several times, with each touch gradually getting closer to the area at the beginning of the exposure. John was able to habituate to his anxiety with each successive touch of the toilet seat until he reached the initial

location. John's case illustrates another way of handling incidental exposures by returning to the exposure and successively working back to the initial feared stimulus or situation that triggered the strong anxiety reaction.

Mental Rituals

Mental rituals are covert compulsive behaviors that are performed to neutralize anxiety (Salkovskis & Westbrook, 1989). Since they are not conspicuous like overt rituals (e.g., washing, ordering), mental rituals may be difficult for a therapist to detect and address in therapy. Examples of mental rituals include prayer, counting, analyzing, and mentally replaying situations. Furthermore, these insidious rituals may undermine a client's ability to progress in treatment by interfering with their ability to habituate to anxiety. Similar to overt rituals, as clients become reliant on mental rituals to neutralize anxiety, these rituals can consume increasing amounts of time and energy to complete, thus impairing an individual's level of functioning. For example, if a client repeats mental prayers while performing an exposure, the client may reinforce the distressing nature of their obsessions and feel compelled to respond to anxiety by praying compulsively. Since a therapist can never be completely sure a client is not engaging in mental rituals, it is important for clients to be invested in eliminating these covert behaviors.

To check for the presence of mental rituals in session, therapists can ask clients to describe what is going through their minds during an exposure task. Often times, clients will narrate their thought processes and describe how they readily employ mental rituals without recognizing how their rituals may be preventing them from habituating to their feelings of anxiety naturally. If clients appear to be preoccupied or mentally distracted during behavioral exposures, it is important to immediately probe clients for the presence of mental rituals, and if clients appear to be employing these rituals but deny their presence, the therapist will have to explain that therapy will not work if avoidance (either physical or mental) continues (Freeston & Ladouceur, 1999). Finally, if avoidant behavior continues to persist in session, the therapist will have to re-evaluate a client's motivation for treatment and possibly suspend treatment until a client follows the therapist's recommendations (Persons, 1993).

To illustrate how to address mental rituals successfully, we discuss the case of Tina, a client with obsessive fears about what happens after death. She feared that there was no heaven and that people simply stopped existing at death. She avoided anything that reminded her of death (e.g.,

TV shows, cemeteries, etc.). In monitoring her thought process during initial exposures, it became apparent that she was mentally ritualizing during the exposures (i.e., she was repeating that "it is okay" and that she would go to heaven when she died). Not only was she encouraged to not reassure herself in this manner, but she was encouraged to increase the intensity of the exposure by repeating the opposite (i.e., "it is possible that there is not a heaven"). By not ritualizing during exposures, she found that her anxiety actually subsided much faster, thus making the exposure sessions considerably more tolerable.

High Anxiety Sensitivity

If clients doubt their ability to cope with feeling anxious, they will take extreme measures to avoid anxiety-provoking stimuli. Then, in the absence of successfully coping with anxiety, avoidant behavior associated with high anxiety sensitivity can prevent clients from habituating to their anxious feelings. In our clinical experience, clients with exceptionally high anxiety sensitivity are often reluctant to seek exposure-based treatment for OCD in the first place. It is often only after other treatments have failed or after much convincing from family members that they seek this form of therapy. Once these patients are in treatment, it is generally challenging to get them to engage in exposure tasks. While it is good practice to slowly progress up the client's fear hierarchy, this is particularly important for those clients who are on the higher end of the anxiety sensitivity continuum. These clients may also benefit from having success with imaginal exposures before they attempt *in vivo* exposures, and with breaking down *in vivo* exposures into smaller actions. A complicating factor, however—and what often makes this group of clients so difficult to treat—is that the items on their fear hierarchies often cluster at the top (e.g., SUDS of 80 or higher). In this situation, whatever exposure initially attempted, including imaginal exposures, will likely cause considerable distress. Given their high levels of anxiety, clients with high anxiety sensitivity may benefit from medication prior to initiating CBT. Regardless, as part of the psychoeducational and informed consent process, it is imperative that the clients are prepared for the fact that treatment is going to be challenging. Clients generally conclude that the potential rewards are worth the short-term discomfort they may encounter as a result of treatment. To illustrate, we briefly discuss Tim, who presented with obsessional fears of a sexual nature (i.e., fears of inappropriately touching children). In developing his fear hierarchy, all of the items on his fear hierarchy clustered at the top. His lowest rated item was an imaginal exposure (SUDS of 80), which was the exposure with

which he started. During this first exposure, the client became so anxious he began to dry heave. Despite his high level of anxiety and even physical symptoms of anxiety, the client was encouraged to stay with the exposure until his anxiety decreased. Somewhat reluctantly, he agreed to stay with the exposure and his anxiety eventually subsided. For Tim, this was a powerful learning experience and it set him on the road to overcoming his symptoms. A challenge in these situations, particularly for beginning clinicians, is maintaining composure. We recommend clinical consultation or self-cognitive restructuring for clinicians struggling to manage their own anxiety. Regardless of how much experience a therapist has, we can all benefit from reframing client anxiety as something that is necessary to get them better.

CONCLUSION

Clinicians treating OCD with CBT are likely to encounter difficult situations in their practice. This paper highlighted five issues that, in our clinical experience, arise with relative frequency in the implementation of CBT for OCD. These include when clients fail to habituate during an exposure, when therapists and/or clients misjudge how much anxiety an exposure will actually cause in a client, incidental exposures, mental rituals, and high anxiety sensitivity. In highlighting these issues, we aim to increase clinician awareness of these challenges and to offer suggestions for managing them so that clinicians will be better prepared to handle these and other challenges that may arise during exposure-based therapy. While CBT is generally a safe and effective treatment, exposures can and do go awry, and the manner in which clinicians navigate those challenges may strongly influence treatment outcomes. In addition, increased clinical judgment and preparedness, particularly when clinicians are confronted with critical incidents, may reduce high premature termination rates of clients with OCD undergoing CBT. The issues encountered in the treatment of OCD are varied, and the topics addressed in this paper are by no means exhaustive. Further clinical reports are needed that discuss other challenges that arise in the implementation of CBT such as the challenges associated with lack of insight, lack of motivation, ego-syntonic obsessive-compulsive symptoms, poor treatment compliance, and family interference with treatment (e.g., family accommodation, high expressed emotion).

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