Clinical Feedback About Empirically Supported Treatments for Obsessive-Compulsive Disorder

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Previous evidence for the treatment of obsessive-compulsive disorder (OCD) has been derived principally from randomized controlled trials. As such, evidence about the treatment of OCD has unilaterally flowed from researchers to clinicians. Despite often having decades of experience treating OCD, clinicians' feedback on their clinical observations in using these treatments has not been solicited. The current study contacted clinicians for their clinical observations on empirically supported treatments for OCD to identify commonly used cognitive-behavioral techniques and their limitations in their practices. One hundred eighty-one psychotherapists completed an online survey. The average participant practiced psychotherapy for 15 years, worked in private practice, held a doctorate, and treated an average of 25 clients with OCD in their lifetime. In regard to the most common techniques, behavioral strategies involving exposure to a feared outcome and prevention of a compulsive ritual were the most frequent group of interventions, followed by techniques that attempted to identify and challenge irrational thoughts. However, the majority of participants also reported incorporating mindfulness or acceptance-based methods. Based on therapists' reports, the most common barriers to the efficacy of cognitive-behavioral interventions included limited premorbid functioning, chaotic lifestyles, controlling and critical families, OCD symptom severity, OCD symptom chronicity, and comorbidities. This study provides insight into common practices and limitations in clinical practice to inform future clinically relevant treatment research.

OBSESSIVE-COMPULSIVE DISORDER (OCD) IS defined by intrusive and recurrent thoughts, images, or desires that cause marked distress, which are ignored or nullified through rigid rules or repetitive behaviors (American Psychiatric Association, 2013). The annual prevalence of OCD is estimated to be 1.1–1.8% across cultures (Weissman et al., 1994), and typically has a bimodal age of onset, occurring frequently before the age of 10 and after the age of 17, with cases of earlier onset coinciding with more symptoms and higher comorbidity rates (Rosario-Campos et al., 2001). A large proportion of persons with OCD have lifetime diagnoses of other anxiety disorders (76%), depressive disorders (40%), bipolar disorder (23%), impulse disorders (56%), and substance abuse (39%; Ruscio, Stein, Chiu, & Kessler, 2010). Comorbidity is also associated with more OCD symptoms compared with those without comorbidity. Perhaps most significantly, even without comorbidity, OCD is associated with substantial life impairment and distress (Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009; Ruscio et al., 2010).

In regard to its symptoms, prominent theories on the mechanisms of OCD include thought–action fusion and maladaptive beliefs (Williams, Lau, & Grisham, 2013) as well as behavioral reinforcement

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cycles (Gillan & Robbins, 2014). Cognitive theories emphasize that fundamental underlying tenets (e.g., "germs are bad") in an individual drive the formation of specific illogical beliefs (e.g., "touching the toilet seat has a high probability of killing me"), which then contribute to the formation of compulsive styles (e.g., "washing my hands over and over can protect me"). In support of this, Abramowitz, Khandker, Nelson, Deacon, and Rygwall (2006) have shown that dysfunctional beliefs predict the development of OCD symptoms. Behavioral theorists, however, emphasize that OCD symptoms are driven principally by reinforcement cycles of repetitive behavior and that the cognitive symptoms are a consequence, rather than cause, of OCD symptoms (Cougle & Lee, 2014; Gillan & Robbins, 2014).

As knowledge grows about the factors that maintain OCD symptoms, the need for effective treatments becomes the next important step. Current treatments for OCD include cognitive-behavioral therapy (CBT), such as exposure and response prevention (ERP); cognitive therapy (CT); acceptance and commitment therapy (ACT; e.g., Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Twohig et al., 2010; van Oppen et al., 1995); psychodynamic therapy (Chlebowski & Gregory, 2009); and medication, including serotonergic medication such as clomipramine (Soomro, Altman, Rajagopal, & Oakley-Browne, 2008). However, only ERP (Foa, Steketee, Grayson, Turner, & Latimer, 1984; Franklin et al., 2000; van Oppen et al., 1995), CT (Abramowitz, 1997; van Oppen et al., 1995), and their combination (CBT; Jónsson & Hougaard, 2009) are considered "well-established treatments" based on criteria established by Chambless and Hollon (1998).

Both ERP and CT fall within the broader realm of CBT. Accordingly, both treatments include some of the same components, namely psychoeducation (i.e., teaching clients about symptoms of OCD and aspects that help to maintain OCD), anxiety monitoring (actively tracking anxiety symptoms and their cues), and assigning clients homework to practice techniques discussed in the therapy outside the session (Abramowitz, 1996). The principal focus of ERP involves the establishment of an anxiety hierarchy, in which feared outcomes are placed onto a graded scale. This graded scale is then used during exposure wherein the client confronts the feared outcome and is prevented from engaging in any compulsions. CT involves identifying irrational beliefs, asking clients to question the logic of their beliefs, and developing attitudes of a scientist in which the beliefs are then tested (Steketee, 1999).

Although clinical trials have demonstrated efficacy, approximately 21% of clients do not show statistically significant improvement from CBT (Piacentini, Bergman, Jacobs, McCracken, & Kretchman, 2002). Moreover, about 40–50% of clients do not show clinically significant change (Jacobson, Follette, & Revenstorf, 1984), and approximately 75% still demonstrate OCD symptoms after treatment (Fisher & Wells, 2005). Thus, although CBT has established the most empirical support of any treatment for OCD, there is clearly room for improvement.

A number of factors have been theorized by researchers as impediments to CBT for OCD. Such factors include low insight (Storch et al., 2010), family accommodations (Barrett, Healy-Farrell, & March, 2004), pediatric autoimmune neuropsychiatric disorders associated with streptococcus onset (Storch et al., 2006), and comorbidity (Overbeek, Schruers, Vermetten, & Griez, 2002). Of these variables, the only significant predictors of positive outcome from CBT have been less comorbid depression (Overbeek et al., 2002), greater focus on in-session exposure versus out-of-session exposure (Abramowitz, 1996), lower level of certainty of disastrous outcomes (Foa, Abramowitz, Franklin, & Kozak, 1999), fewer family accommodations to OCD symptoms (Amir, Freshman, & Foa, 2000), better family environment (Barrett, Farrell, Dadds, & Boulter, 2005), and less negative family attributions about OCD symptoms (Renshaw, Steketee, & Chambless, 2005). Thus, although many predictors have been theorized to impede treatment gains, many of them thus far have been based on speculation rather than data. More importantly, although a number of studies have investigated predictors of symptom change and incorporated changes into CBT for OCD, little is known about whether these actually impact treatment outcomes in clinical practice.

In addition to not knowing which factors impact outcomes in clinical practice, ideas for what might limit the success of CBT for OCD have been flowing unidirectionally from researchers to practitioners. Thus, despite decades of experience in treating OCD, therapists' feedback on their clinical observations have not been solicited. To bridge this gap, Marvin Goldfried, Michelle Newman, Louis Castonguay, Jairo Fuertes, Jeffrey Magnavita, Linda Sobell, and Abraham Wolf, in collaboration with the American Psychological Association's Divisions 12 (Society of Clinical Psychology) and 29 (Society for the Advancement of Psychotherapy), created a way that practitioners could provide feedback to researchers about empirically supported treatments for anxiety disorders (Goldfried et al., 2014). To date, this

"Two-Way Bridge Between Research and Practice" initiative has reported feedback from therapists on their experiences with social anxiety, generalized anxiety disorder (GAD), and panic disorder (McAleavey, Castonguay, & Goldfried, 2014; Szkodny, Newman, & Goldfried, 2014; Wolf & Goldfried, 2014).

The current study extended this initiative, and reported the results of a survey for practicing therapists that asked about their clinical experiences in the assessment and treatment as well as obstacles they have experienced in the treatment of OCD. This allowed clinicians to provide valuable feedback about their experiences implementing empirically supported treatments for OCD outside of the laboratory, with the goal of shedding light on variables that were perceived to contribute to difficulties in treating this clinical problem.

Method

PROCEDURE

Through the initiative of Division 12 and Division 29 of the American Psychological Association, the survey was designed to identify reported common assessment practices, therapy practices, and limitations of empirically supported treatments for OCD. The survey was constructed based on commonly practiced techniques in CBT for OCD (Steketee, 1999). Next, experts on the nature and treatment of OCD were solicited to provide feedback, which was used to revise the survey. The final measure consisted of demographic information (including education, training, and previous experiences), practices in assessing OCD symptoms, treatment techniques for OCD, and barriers to effective treatment. The potential barriers included the following subsections: OCD symptomatology and associated features, client beliefs about OCD, other client problems and characteristics, client social system, client treatment expectations, client motivation, therapy relationship issues, and the cognitive-behavioral interventions themselves.

The format of the surveys was consistent with the implementation of previous surveys within the same initiative (McAleavey et al., 2014; Szkodny et al., 2014; Wolf & Goldfried, 2014). However, whereas previous surveys had only asked if participants had or had not experienced limitations to treatment for a given item, they did not assess how often the problems had occurred. The present survey attempted to improve upon these prior surveys by obtaining information about how often each potential limitation to treatment occurred.

PARTICIPANTS

Participants were recruited using the following listservs and Web sites: Association for Behavioral and Cognitive Therapies; Society for Psychotherapy Research; Society for the Exploration of Psychotherapy Integration; and American Psychological Association Divisions 12 (Clinical Psychology), 17 (Counseling Psychology), 29 (Psychotherapy), and 42 (Psychologists in Private Practice). In addition, participants were recruited through several English-speaking listservs throughout the world (e.g., Canada, United Kingdom, Australia). Two hundred fifty-three participants began the survey, but only those who completed 80% or more (N = 181) were included in the final analyses. These individuals completed an average of 92% of the survey. There were 72 noncompleters who completed an average of 46% of the survey.

To determine if noncompleters differed from completers, we compared the completers' demographic information (see Table 1), therapist education (see Table 2), therapist characteristics (see Table 3), and therapist experience (see Table 4). All continuous data (e.g., age) were compared using between-sample t tests, whereas chi-square tests of independence were used for categorical data. The results revealed that survey completers were significantly older and were more likely to have received OCD training via graduate school, books, journals, videos, workshops, and internship compared with noncompleters. Significantly more completers held a private practice, practiced in outpatient treatment centers and inpatient units, and had treated over 100 clients. Whereas a higher percentage of completers had treated OCD clients within 3–6 months, noncompleters reported treating their clients for less than 3 months.

The current report is based on the 181 survey completers (M age = 45.84, 60% female, 91.2% Caucasian, 3.9% Hispanic/Latino, 1.7% more than one ethnicity, 1.1% African American, 1.1% Asian American, and 0.6% other ethnicity).

Results

THERAPIST EDUCATION, ORIENTATION, AND EXPERIENCE

The majority (61.3%) of respondents held a Ph.D. in clinical psychology. In addition, 7.2% held a Psy.D., 6.6% were current graduate students, 6.1% held a Ph.D. in counseling psychology, and 5.5% held an MSW. Other degrees constituted a total of 13.3% of the remaining respondents. Respondents' degrees were conferred between 1962 and 2012. The majority received their training in OCD treatment through books, journals, and/or videos (65.2%), graduate school (58.0%), and workshops (51.9%). Less than half of the sample received training through postdoctoral experience, internship, peer supervision,

Table 1
Demographics

	Completers	Noncompleters	Statistic		
	M (SD)	M (SD)	t	df	p
Age	N = 179	N = 52	3.097	101 [a]	0.003
	45.84 (13.01)	40.42 (10.47)			
	% (n)	% (n)	χ^2	df	
Gender	N = 180	N = 53	0.427	1	0.492
Male	40.0 (72)	45.3 (24)			
Female	60.0 (108)	54.7 (29)			
Ethnicity	N = 181	N = 53	9.722	6	0.137
Caucasian	91.2 (165)	83.0 (44)			
African	1.1 (2)	0.0 (0)			
American		0.0 (0)			
Hispanic/Latino	3.9 (7)	3.8 (2)			
Asian American	1.1 (2)	1.9 (1)			
More than one ethnicity	1.7 (3)	1.9 (1)			
Other	0.6 (1)	5.7 (3)			

Note. M = mean; SD = standard deviation.
[a] Equal variances not assumed based on significant Levene's test: $F = 8.190$, $p = .005$.

or other types of training (Table 2). Therapists predominantly identified as behavioral (45.9%) and cognitive (41.2%) in their theoretical orientations. Psychodynamic, experiential/humanistic, family systems, and other approaches informed participants' treatments on average less than 6% per orientation (Table 3).

Most respondents had more than 10 years of experience (65.9%), and practiced in outpatient (58.6%) or private practice (57.5%) settings. Few respondents practiced in inpatient (11.6%) or counseling centers (3.3%). The majority saw clients between 0 and 20 hours per week (61.7%). The average respondent had treated 30–40 OCD clients

Table 2
Therapist Training and Education

	Completers	Noncompleters	Statistic		
	M/% (n)	M/% (n)	χ^2	df	p
Highest degree completed	N = 181	N = 53	16.821	11	0.113
Ph.D. in clinical psychology	61.3 (111)	66.0 (35)			
Ph.D. in counseling psychology	6.1 (11)	3.8 (2)			
Ph.D. in educational psychology	1.1 (2)	1.9 (1)			
Ph.D. in social work	0.0 (0)	1.9 (1)			
Psy.D.	7.2 (13)	0.0 (0)			
M.D.	2.8 (5)	1.9 (1)			
Ed.D.	0.6 (1)	1.9 (1)			
MSW	5.5 (10)	1.9 (1)			
MSc	1.7 (3)	5.7 (3)			
MA/MS in counseling psychology	1.1 (2)	0.0 (0)			
Graduate student	6.6 (12)	13.2 (0)			
Other	6.1 (11)	1.9 (1)			
Training in CBT for OCD	N = 181	N = 72	t		
Graduate school	58.0 (105)	38.9 (28)	7.554	1	0.006
Books, journals, videos	65.2 (118)	36.1 (18)	17.766	1	<0.001
Workshops	51.9 (94)	33.3 (24)	7.161	1	0.007
Postdoctoral experience	44.8 (81)	31.9 (23)	3.490	1	0.062
Internship	43.6 (79)	26.4 (19)	6.464	1	0.011
Peer supervision	39.2 (71)	27.8 (20)	2.932	1	0.087
Other	14.4 (26)	5.6 (4)	3.824	1	0.051

Note. M = mean; CBT = cognitive-behavioral therapy; OCD = obsessive-compulsive disorder.

Table 3
Therapist Characteristics

	Completers	Noncompleters			
	M% (SD)	M% (SD)	t	df	p
Degree theoretical orientations guide practice	N = 180	N = 53			
Cognitive	41.16 (20.47)	40.51 (18.86)	0.208	232	0.836
Behavioral	45.92 (23.19)	48.26 (22.52)	−0.652	232	0.515
Psychodynamic	5.33 (12.72)	6.45 (15.28)	−0.538	232	0.591
Experiential/humanistic	3.19 (8.97)	4.25 (10.80)	−0.718	232	0.473
Family systems	4.77 (9.68)	7.55 (12.37)	−1.503	74.224 [a]	0.137
Other	2.86 (8.60)	3.09 (14.31)	−0.150	232	0.087
Success in reducing OCD symptoms	N = 173	N = 47	−1.070	218	0.286
	75.24 (17.69)	78.26 (14.80)			
OCD clients on medication	N = 173	N = 44	0.918	215	0.36
	61.55 (27.01)	57.27 (29.80)			

Note. M = mean; SD = standard deviation; OCD = obsessive-compulsive disorder.
[a] Equal variances not assumed based on significant Levene's test: $F = 8.161$, $p = .005$.

in their lifetime, but there was substantial heterogeneity, varying from fewer than 10 to over 100 (Table 4).

CLIENT CHARACTERISTICS

Therapists reported that 69.6% of OCD clients had comorbid disorders on average, and 61.6% of their OCD clients were concurrently on medication during treatment. Clients were typically in therapy for OCD between 3 and 6 months (37.4%) or 6 months to 1 year (40.8%).

ASSESSMENT OF OCD

Most respondents reported using self-report (80.1%), structured/semistructured interviews (76.8%), and clinician-administered measures (58.6%) to assess OCD before therapy. Approximately half of respondents administered informal interviews, and few used planned behavioral tests (11.6%) or physiological assessments (2.8%) (Table 5). During treatment, most respondents monitored OCD symptoms via self-report measures (80.1%) and informal interviews (53.0%), and fewer administered structured/semistructured interviews (27.1%), planned behavioral tests (26.0%), or physiological assessments (2%). Compared with pretreatment, there was decreased use of structured/semistructured interviews (49.7% decrease) and clinician-administered measures (17.7% decrease), as well as increased use of planned behavioral tests (14.4% increased).

TREATMENT OF OCD

In regard to treatment, all but one respondent incorporated psychoeducation about the nature of obsessions and compulsions (99.4%), and all but

two respondents reported using exposure to anxiety-provoking stimuli or anxiety-provoking imagery (90%). Similarly, the overwhelming majority utilized response prevention of ritualistic behaviors (95.6%). Most also used out-of-session behavioral exposure homework and assigned out-of-session behavioral experiments (93.4%). In addition, most used core components of CT, including (a) challenging cognitive distortions (82.9%), (b) identifying and addressing superstitious beliefs about obsessions and compulsions (82.3%), (c) cognitive restructuring of negative beliefs (78.5%), (d) Socratic questioning (75.1%), and (e) assigning out-of-session cognitive homework (69.6%). Just over half of respondents utilized mindfulness or acceptance-based methods (53.6%). Thus, ERP was reported to be more frequently used than core components of CT, and both were more frequently used than mindfulness-based interventions. In addition, most reported using both cognitive and behavioral interventions (90.6%), with few respondents using only behavioral (9.9%) or cognitive interventions (2.8%).

With respect to symptom monitoring, most respondents (a) had patients track obsessions and compulsions and their outcome (83.4%), (b) helped clients identify anxiety and worry triggers (81.2%), and (c) helped clients identify negative thoughts and physical sensations in response to anxiety-provoking situations (77.9%). Thus, most had clients monitor their symptoms and helped them to connect these triggers to their OCD symptoms.

Other frequently used strategies included (a) assigning, identifying, and addressing intolerance of uncertainty (74.0%); (b) focusing on in-session indications of OCD as they arose (72.4%); (c) using self-help material (58.6%); (d) helping to clarify what was important to clients' OCD (55.2%); and (e)

Table 4
Therapist Experience

| | Completers | Noncompleters | Statistic | | |
	% (n)	% (n)	χ^2	df	p
Psychotherapy experience	N = 179	N = 54	6.853	4	0.144
Less than 10 years	34.1 (61)	48.1 (26)			
10–20 years	31.3 (56)	32.5 (19)			
21–30 years	17.3 (31)	9.3 (5)			
31–40 years	12.8 (23)	5.6 (3)			
Over 40 years	4.5 (8)	1.9 (1)			
Clinical setting	N = 181	N = 72	t		
Private practice	57.5 (104)	34.7 (25)	10.655	1	0.001
Outpatient treatment center	58.6 (106)	40.3 (29)	6.921	1	0.009
Counseling center	3.3 (6)	5.6 (4)	0.681	1	0.409
Inpatient unit	11.6 (23)	2.8 (2)	4.853	1	0.028
Weekly client contact	N = 180	N = 53	5.248	3	0.154
Less than 10 hours	30.6 (55)	47.2 (25)			
10–20 hours	31.1 (56)	26.4 (14)			
21–30 hours	25.6 (46)	17.0 (9)			
Over 30 hours	12.8 (23)	9.4 (5)			
			χ^2		
Experience using CBT for OCD	N = 179	N = 53	8.508	4	0.075
Less than 10 years	48.0 (86)	66.0 (35)			
10–20 years	27.4 (49)	24.5 (13)			
21–30 years	15.6 (28)	9.4 (5)			
31–40 years	7.8 (14)	0.0 (0)			
Over 40 years	1.1 (2)	0.0 (0)			
Number of OCD clients treated	N = 181	N = 51	12.935	6	0.044
Less than 10	24.9 (45)	37.3 (19)			
10–20	13.8 (25)	17.6 (9)			
21–30	11.6 (21)	19.6 (10)			
31–40	8.3 (15)	3.9 (2)			
41–50	11.6 (21)	6.1 (3)			
51–100	9.9 (18)	11.8 (6)			
Over 100	19.9 (36)	7.8 (4)			
Typical length of OCD treatment	N = 179	N = 52	11.492	3	0.009
Less than 3 months	6.7 (12)	21.2 (11)			
3–6 months	37.4 (67)	23.1 (12)			
6 months to a year	40.8 (73)	36.5 (19)			
Over a year	15.1 (27)	19.2 (10)			

Note. CBT = cognitive-behavioral therapy; OCD = obsessive-compulsive disorder.

motivational enhancement (52.5%). Less commonly used strategies included using feedback from others (48.1%), enhancing self-efficacy (44.2%), breathing retraining (38.1%), relaxation training (35.9%), focusing on developmental roots of OCD (35.4%), imagery training (33.1%), assertiveness training (21%), communication training (16%), and biofeedback (2.2%). In regard to the setting, almost all of

Table 5
Assessment of OCD

| | Pretreatment | Periodic Monitoring | Posttreatment |
	N = 181	N = 181	N = 181
Self-report	80.1 (145)	80.1 (145)	76.2 (138)
Structured/semistructured interview	76.8 (139)	27.1 (49)	36.5 (66)
Unstructured or informal interview	49.2 (89)	53.0 (96)	48.1 (87)
Clinician-administered measures	58.6 (106)	40.9 (74)	43.6 (79)
Planned behavioral test	11.6 (21)	26.0 (47)	17.7 (32)
Physiological assessment	2.8 (5)	2.2 (4)	1.7 (3)

Note. Cells depict percentage with sample size (n) in parentheses; OCD = obsessive-compulsive disorder.

the respondents used individual therapy (96.1%), whereas group therapy was much less common (19.9%).

BARRIERS TO TREATMENT

Despite the barriers to success listed below, it is important to note that therapists reported that they were able to successfully reduce OCD symptoms in 75.2% of their clients on average. For each barrier, clinicians rated the frequency that it interfered with therapy on a 4-point Likert scale (0 = *never*, 1 = *rarely*, 2 = *sometimes*, and 3 = *often/always*). For barriers related to OCD symptoms, the most frequently endorsed were severity of OCD symptoms with 64% of participants endorsing sometimes (typical range: sometimes–often/always[1]), chronicity of OCD with 59% of the sample indicating that problems occurred sometimes (typical range: sometimes–often/always), functional impairment with 61% of the sample indicating that it interfered with treatment sometimes (typical range: sometimes), and attentional biases with 51% of the sample endorsing sometimes (typical range: rarely–sometimes). However, 48% of participants endorsed that panic attacks rarely interfered with treatment progress (typical range: rarely–sometimes). (See Table 6).

With regard to clients' beliefs that interfered with treatment progress, the most frequently endorsed included beliefs that worries were realistic (41% sometimes, typical range: rarely–sometimes), that obsessive rituals actually prevented bad things from happening (37% sometimes, typical range: rarely–sometimes), that obsessive rituals were helpful (39% sometimes, typical range: rarely–sometimes), that obsessive rituals helped them prepare for the worst (43% sometimes, typical range: rarely–sometimes), that problems were due to external factors (e.g., situation, other people; 40% sometimes, typical range: rarely–sometimes), and that being obsessive-compulsive was part of their personality and unchangeable (41% sometimes, typical range: rarely–sometimes). (See Table 7).

Of reported client characteristics, the most frequently reported interferences were an inability to work independently between sessions (44% often/always, typical range: sometimes–often/always), resistance to directiveness of treatment (e.g., non-compliance with homework) (42% often/always, typical range: sometimes–often/always), limited premorbid functioning (50% sometimes, typical range: sometimes–often/always), unwillingness to give up

safety behaviors (49% sometimes, typical range: sometimes–often/always), and chaotic lifestyles (54% sometimes, typical range: sometimes–often/always). The next most frequently endorsed problems were depressed mood/mood disorders (69% sometimes, typical range: sometimes), personality disorders (43% sometimes, typical range: sometimes–often/always), perfectionistic style (53% sometimes, typical range: sometimes–often/always), and psychotic and dissociative disorders (39% often/always, typical range: sometimes–often/always; see Table 8 for all other client-related problems to treatment). (See Table 8).

Regarding interfering social systems, the most frequently endorsed issues were family members being controlling and critical (55% sometimes, typical range: rarely–sometimes), having others reinforce/support the client's symptoms/dependency (44% sometimes, typical range: sometimes–often/always), and family being unsupportive of treatment (37% sometimes, typical range: rarely–often/always). Similarly, stress at home, school/work, or socially (58% sometimes, typical range: sometimes–often/always) and being trapped in a dysfunctional home (60% sometimes, typical range: sometimes), also impacted symptom reduction. (See Table 8).

With respect to client expectations, pessimism about the therapy (56% sometimes, typical range: rarely–sometimes), thinking that treatment would be brief and easy (46% sometimes, typical range: rarely–sometimes), and expecting that the therapist would do all of the work (39% sometimes, typical range: rarely–often/always) also interfered with symptom reduction. In addition, premature termination (48% sometimes, typical range: sometimes–often/always) and minimal motivation at the outset of treatment (55% sometimes, typical range: sometimes–often/always) were most frequently endorsed as interfering with treatment. The most frequently interfering relationship issues were weak alliance (43% sometimes, typical range: rarely–sometimes), therapists' frustration with progress (45% rarely, typical range: rarely–sometimes), and therapists' negative feelings toward clients (50% rarely, typical range: never–sometimes). (See Table 9).

In regard to perceived barriers to treatment, the most frequently reported problems were that the treatment does not deal with comorbid problems (45% sometimes, typical range: rarely–sometimes), simulating anxiety in session is difficult (42% sometimes, typical range: rarely–sometimes), and insufficient focus on affect tolerance/regulation (41% sometimes, typical range: rarely–sometimes). Last, a slight majority of respondents (54.1%) believed that more than symptom reduction was needed in OCD treatment. (See Table 10).

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[1] Note that the typical range is defined as endorsement by 20% of the sample or more.

Table 6
Techniques Used in Conducting CBT for OCD

	% (*n*)
	N = 181
Psychoeducation about the nature of obsessions and compulsions	99.4 (180)
Exposure to anxiety-provoking stimuli or anxiety-provoking imagery	98.9 (179)
Individual therapy	96.1 (174)
Response prevention of ritualistic safety behaviors	95.6 (173)
Assigning out-of-session behavioral exposure homework	93.4 (169)
Using both cognitive and behavioral interventions	90.6 (164)
Having patient monitor obsessions and compulsions and their outcome	83.4 (151)
Challenging cognitive distortions	82.9 (150)
Identifying and addressing directly superstitious beliefs about obsessions and compulsions	82.3 (149)
Identifying anxiety and worry triggers	81.2 (147)
Cognitive restructuring of negative beliefs (e.g., putting situation in perspective)	78.5 (142)
Assigning out-of-session behavioral experiments	78.5 (142)
Identifying negative thoughts and physical sensations or emotions in response to anxiety-provoking situations	77.9 (141)
Socratic questioning to confront thoughts about obsessive or ritualistic behaviors	75.1 (136)
Identifying and addressing directly intolerance of uncertainty	74.0 (134)
Focus on in-session indications of OCD as they arise	72.4 (131)
Assigning out-of-session cognitive homework	69.6 (126)
Self-help material	58.6 (106)
Helping clarify what is important to the patient (values clarification)	55.2 (100)
Mindfulness or acceptance-based methods	53.6 (97)
Motivational enhancement	52.5 (95)
Using feedback from others about the patient's OCD	48.1 (87)
Enhancing self-efficacy in place of rituals	44.2 (80)
Breathing retraining (e.g., diaphragmatic breathing)	38.1 (69)
Relaxation training (e.g., progressive muscle relaxation, applied relaxation training)	35.9 (65)
Helping the patient understand developmental roots of anxieties and worries	35.4 (64)
Imagery training	33.1 (60)
Resolution of worrisome conflicts	23.2 (42)
Family therapy	21.5 (39)
Assertiveness training	21.0 (38)
Group therapy	19.9 (36)
Communication training	16.0 (29)
Using only behavioral interventions (without cognitive interventions)	9.9 (18)
Using only cognitive interventions (without behavioral interventions)	2.8 (5)
Biofeedback	2.2 (4)

Note. CBT = cognitive-behavioral therapy; OCD = obsessive-compulsive disorder.

Discussion

The current study, which was part of the Two-Way Bridge Between Research and Practice initiative, sought to obtain practitioners' feedback on empirically supported therapies for OCD. Therapists reported on the techniques they used in assessment and treatment, as well as treatment barriers. In interpreting feedback from this survey, it is important to understand how effectiveness reports in this survey compared with effectiveness rates of randomized controlled trials (RCTs). Therapists reported an average of 75% success in reducing OCD symptoms, which is similar to the 79% success rates from an RCT (Piacentini et al., 2002). This is also in line with a recent meta-analysis suggesting that effectiveness

studies were comparable to RCTs for OCD (Stewart & Chambless, 2009).

Given that the results suggest that therapists believed that approximately a quarter of clients with OCD did not significantly reduce their OCD symptoms, it is important to focus on issues that they believed interfered with therapy. In the current study, therapists reported that a number of issues typically interfered with treatment sometimes to often/always. Accordingly, many of the problems reported here should be addressed in CBT.

When considering treatment implications, it is important to note characteristics of our sample. Therapists primarily held doctorates, identified as primarily cognitive or behavioral in orientation, averaged 15 years of psychotherapy experience,

Table 7
Perceived Barriers to Treatment Progress Related to OCD

	0	1	2	3
OCD symptomatology and associated features (N = 181)				
Severity of the OCD symptoms	2%	10%	**64%**	24%
Chronicity of the OCD symptoms	3%	13%	**59%**	25%
Functional impairment (e.g., travel, work/school, social)	2%	19%	**61%**	18%
Attentional or information-processing bias toward negative information	11%	31%	**51%**	7%
Panic attacks	16%	**48%**	34%	2%
Substance abuse	12%	21%	**42%**	25%
Other anxiety disorders	3%	29%	**59%**	8%
Depressed mood/mood disorder	3%	14%	**69%**	14%
Personality disorder(s)	7%	19%	**43%**	30%
Psychotic and dissociative disorder	19%	19%	23%	**39%**
History of trauma	15%	36%	**43%**	6%
History of physical or sexual abuse	24%	**47%**	28%	2%
Other Comorbidity (e.g., eating, somatoform, sleep, sexual, and impulse disorders)	11%	22%	**55%**	12%
Client beliefs about OCD (N = 181)				
Anxiety and worries are realistic	12%	34%	**41%**	13%
Obsessive rituals actually prevents bad things from happening	17%	30%	**37%**	16%
Obsessive rituals are helpful	15%	34%	**39%**	13%
Obsessive rituals helps him or her prepare for the worst	17%	32%	**43%**	9%
Problems are due to external factors (e.g., situation, other people)	17%	34%	**40%**	9%
Being obsessive-compulsive is part of his or her personality and unchangeable	14%	37%	**41%**	7%
Obsessive rituals helps him or her to be motivated to get things done	17%	**43%**	33%	6%
Obsessive rituals helps him or her solve problems	19%	**43%**	31%	8%
OCD is biologically based, and thus cannot be treated by psychotherapy	28%	**43%**	25%	5%
Loss of anxiety will have negative impact on relationship(s)	32%	**44%**	22%	3%
Being obsessive-compulsive is abnormal/dangerous	30%	**51%**	17%	2%

Note. Cells depict the frequencies of each response for each item; modal response is bolded: 0 = *never*, 1 = *rarely*, 2 = *sometimes*, and 3 = *often/always*; OCD = obsessive-compulsive disorder.

worked in outpatient settings, saw clients approximately 15 hours per week, and had treated approximately 25 clients with OCD in their lifetime. Thus, the average respondent was well educated and had treated high numbers of OCD clients in his or her career. Consequently, problems experienced are particularly concerning and noteworthy. In addition, the cumulative amount of clients treated was quite substantial, amassing approximately 7,500 people, about 10 times the sample of a recent meta-analysis of RCTs for OCD (Olatunji, Davis, Powers, & Smits, 2013).

Assessment practices were consistent with manualized treatment of OCD, such as semistructured interviews before treatment and using self-report measures before and during treatment (Steketee, 1999). During treatment, most therapists also helped clients identify triggers and outcomes of their obsessions and compulsions. This is noteworthy because assessment is an essential part of manualized OCD treatment and is used to form exposure hierarchies and educate clients about their symptoms.

Regarding the most commonly implemented therapy practices for OCD, ERP was most frequently endorsed, and more widely practiced than CT. However, evidence from RCTs is mixed regarding the comparative efficacy of these two treatments. Most studies suggested that CT was not significantly different from ERP (Cottraux et al., 2001; Emmelkamp, Visser, & Hoekstra, 1988; Emmelkamp & Beens, 1991; van Oppen et al., 1995). However, in one study, ERP was more successful (McLean et al., 2001). With respect to clinically significant change, however, in a meta-analysis of RCTs, ERP was superior to CT alone (Fisher & Wells, 2005). Despite the greater effort involved in administration of ERP over CT, approximately 9 out of 10 therapists reported using both cognitive and behavioral interventions. Approximately half reported using mindfulness or ACT, which is not a well-established treatment for OCD (Chambless & Hollon, 1998; Twohig et al., 2010). Thus, the reported greater frequency using ERP appears to match its level of empirical support.

Table 8
Perceived Barriers to Treatment Progress Related to the Client

	0	1	2	3
Other client problems and characteristics (*N* = 180)				
Inability to work independently between sessions	2%	15%	38%	**44%**
Resistance to directiveness of treatment (e.g., noncompliance with homework)	2%	19%	36%	**42%**
Premorbid functioning is limited	3%	14%	**50%**	32%
Unwilling to give up safety behaviors	4%	16%	**49%**	31%
Chaotic lifestyle	4%	16%	**54%**	26%
Perfectionistic style	7%	17%	**53%**	23%
Fear of exposure and associated emotional reactions	6%	24%	**54%**	16%
Intellectual/cognitive/introspective ability is limited	10%	32%	**39%**	19%
Patient expects/requests repeated reassurance	8%	35%	**46%**	11%
Dependency/unassertiveness	14%	32%	**45%**	10%
Inability to identify automatic thoughts	12%	36%	**39%**	13%
Inability to identify emotions	11%	40%	**38%**	11%
Low self-esteem/self-efficacy	11%	40%	**42%**	7%
Poor interpersonal skills	12%	39%	**45%**	4%
Problems with medication (e.g., insufficient dosage, frequent changes in dosage during treatment)	14%	38%	**45%**	3%
Low socioeconomic status	21%	**52%**	25%	2%
Fear of rejection	25%	**52%**	21%	2%
Physical problems (e.g., medical disease, disorder, physical injury)	30%	**42%**	27%	1%
Diversity issues associated with ethnicity/race/religion/sexual orientation	**46%**	45%	8%	1%
Client social system (*N* = 179)				
Family is controlling and critical	6%	23%	**55%**	16%
Symptoms/dependency is reinforced/supported	4%	16%	**44%**	36%
Family does not support treatment	7%	30%	**37%**	26%
Stress very high at home, school/work, or socially	5%	16%	**58%**	21%
Trapped in dysfunctional home, school/work, or social situation	4%	17%	**60%**	19%
Family members are very anxious	6%	23%	**58%**	13%
Loss of family member, partner, employment	15%	**44%**	38%	3%
Social isolation of patient	7%	30%	**50%**	13%
Lack of time due to other commitments	6%	30%	**45%**	19%

Note. Cells depict the frequencies of each response for each item; modal response is bolded: 0 = *never*, 1 = *rarely*, 2 = *sometimes*, and 3 = *often/always*.

In terms of specific ERP techniques practiced, most therapists reported using out-of-session homework to administer exposure interventions, and substantially fewer therapists endorsed using ERP in session. In a meta-analysis of CBT for OCD, heavy reliance on in-session exposure predicted more efficacious outcomes than greater reliance on out-of-session exposure (Abramowitz, 1996). Thus, approximately one in five therapists who took our survey might benefit from more in-session exposure. Almost all therapists also reported engaging in response prevention, which is associated with larger treatment gains compared with using exposure without response prevention (Abramowitz, 1996).

Most respondents also reported identifying and addressing discomfort due to the uncertainty of outcomes. This is noteworthy, as clients with greater levels of intolerance of uncertainty tend to do worse in CBT (Boswell, Thompson-Hollands, Farchione,

& Barlow, 2013). Therapists also used self-help material, which was found to improve symptom reduction marginally in clients with OCD when used alone (Kirkby et al., 2000). Relaxation and breathing retraining were used by about a third of participants, and although these tend to be traditional components for other anxiety disorder treatments, they are less commonly used in manualized OCD (O'Sullivan, Noshirvani, Marks, Monteiro, & Lelliott, 1991; Steketee, 1999). Nevertheless, relaxation techniques fail to lead to treatment change when used alone to treat OCD (Fals-Stewart, Marks, & Schafer, 1993).

In terms of barriers to improvement, it is important to note that one of the novel aspects of the current study was an attempt to improve upon the survey used in prior studies by asking for Likert-scale ratings of frequency of occurrence as opposed to allowing for only a presence versus absence response. Thus, the current study collected information that was not

Table 9
Perceived Barriers to Treatment Progress Related to the Psychotherapy Process

	1	2	3	4
Client treatment expectations (*N* = 180)				
Pessimism about therapy (e.g., due to disappointment with past therapy)	3%	31%	**56%**	10%
Treatment will be brief and easy	11%	33%	**46%**	11%
Therapist will do all the work to make things better	9%	29%	**39%**	23%
He or she will be free of all anxiety and worry	8%	32%	**41%**	19%
He or she needs medication to reduce anxiety and worry	11%	31%	**51%**	7%
Symptom reduction is not enough	14%	35%	**46%**	6%
Client motivation (*N* = 181)				
Premature termination	3%	22%	**48%**	28%
Minimal motivation at outset	4%	18%	**55%**	23%
Motivation decreased as patient attributes gains to medication	15%	31%	**45%**	9%
Motivation decreased as some improvement occurs	13%	35%	**47%**	5%
Motivation decreased as patient better understands nature and function of anxiety and OCD	20%	**42%**	30%	8%
Therapy relationship issues (*N* = 177)				
Therapy alliance not strong enough	7%	35%	**43%**	15%
Therapist's frustration with progress	18%	**45%**	32%	5%
Therapist's negative feelings toward patient	21%	**50%**	20%	8%
Patient does not feel his or her distress is sufficiently understood/validated	14%	**48%**	28%	10%
Therapist's reluctance to make patient uncomfortable during exposure	**30%**	29%	26%	16%

Note. Cells depict the frequencies of each response for each item; modal response is bolded: 0 = *never*, 1 = *rarely*, 2 = *sometimes*, and 3 = *often/always*; OCD = obsessive-compulsive disorder.

available in prior studies. Our findings suggested that symptom severity, chronicity, functional impairment, and comorbidity were endorsed as interfering with treatment at least sometimes by between 79 and 88% of the sample. Also, psychosis was endorsed as frequently interfering by 39% of the sample. Similarly, therapists felt that failure to deal with comorbidity was one of the biggest limitations of RCTs (endorsed by 58% of the sample as being a problem between sometimes and often). This is in contrast to a

Table 10
Perceived Barriers to Treatment Progress Related to Problems/Limitations Associated With the Cognitive-Behavioral Intervention

	1	2	3	4
(*N* = 179)				
Intervention method does not deal with comorbid problems/symptoms	15%	28%	**45%**	13%
Simulating anxiety-provoking situations in session is difficult	15%	36%	**42%**	7%
Insufficient focus on affect tolerance/regulation	18%	33%	**41%**	8%
Patient not sufficiently socialized to treatment model	23%	**40%**	29%	8%
Intervention method does not deal with interpersonal problems	26%	**40%**	28%	7%
Anxiety and worry triggers not evident	22%	**44%**	30%	4%
Absence of guidelines for dealing with resistance/noncompliance	29%	**37%**	31%	4%
Intervention method does not deal with linking OCD to other clinical issues	25%	**44%**	22%	8%
Intervention method does not deal with comprehensive or lasting change	28%	**44%**	18%	10%
Intervention method does not deal with fear of interpersonal loss	28%	**44%**	23%	6%
Not enough time for patient to respond to treatment within the time frame of a CBT manual (if using a manual in regular practice)	36%	**29%**	26%	9%
Strict adherence to CBT protocol	33%	**40%**	18%	9%
Relaxation does not work or causes anxiety	34%	**35%**	26%	5%
Treatment is too directive	32%	**49%**	15%	5%
Too much between-session homework assigned	30%	**49%**	18%	3%
Too much time spent lecturing/psychoeducation	**41%**	40%	14%	6%
Triggers for worry and anxiety are not linked to patient's past history	38%	**43%**	16%	3%
Current coping skills are not linked to past	36%	**50%**	12%	2%

Note. Cells depict the frequencies of each response for each item; modal response is bolded: 0 = *never*, 1 = *rarely*, 2 = *sometimes*, and 3 = *often/always*; OCD- = obsessive-compulsive disorder; CBT = cognitive-behavioral therapy.

meta-analysis of RCTs, which did not find that OCD symptom severity, chronicity, or comorbidity interfered with treatment change (Olatunji et al., 2013). It is possible that severity, chronicity, and comorbidity within RCTs may not generalize to the impediments of these variables in real practice.

Several beliefs reportedly interfered with treatment at least sometimes (endorsed by 48–54% of the sample). These included that clients' anxieties and worries were realistic, rituals prevented bad things from happening, rituals were helpful, their anxiety problems were due to external factors, and their OCD symptoms were unchangeable. Such beliefs are commonly reported in clients with OCD (Foa et al., 1995). Despite this, in one study, holding these types of beliefs actually improved treatment outcomes compared with those without these beliefs during the course of ERP (Foa et al., 1999). Corroborating the idea that some cognitive beliefs may not interfere with treatment outcome, client beliefs about obsessions and compulsions being dangerous were reported as rarely to never interfering. The latter findings appear at odds with cognitive theories of OCD, as cognitive beliefs regarding obsessions and compulsions being dangerous have been argued to maintain OCD (Rachman, 1997). Given these inconsistent findings, future effectiveness studies need to examine the degree to which clients' beliefs impact treatment gains in clinical practice.

Inability to work between sessions and resistance to the directiveness of treatment were endorsed by the modal percentage of respondents (42–44%) as often/always interfering with symptom reduction. Importantly, an RCT has also found that an inability to work between sessions limits symptom reduction in CBT for OCD (Park et al., 2014). Likewise, the finding about resistance to the directiveness of treatment corresponds with general evidence that reactance to directiveness can interfere with treatment outcomes from other disorders (Westra, 2011) and may suggest that reducing the directiveness of the treatment for such clients may be important in CBT for OCD (Harwood & L'Abate, 2010).

Limited premorbid functioning and chaotic lifestyles were endorsed between sometimes and often interfering with treatment by 80–82% of respondents. A few alternative therapeutic approaches have attempted to target lifestyle changes in OCD, but have failed to show significant changes in outcomes (Foa et al., 1995, 1999). Thus, chaotic lifestyles and limited premorbid functioning should be addressed in future modifications of CBT for OCD.

One-hundred and thirty-seven (76%) of the therapists also reported that dependency, unassertiveness, reassurance seeking, poor interpersonal skills, and perfectionistic styles interfered with therapy between sometimes and often. This may suggest that when needed, interpersonal therapy modules found in treatment for other disorders may augment treatment for OCD (e.g., Moritz et al., 2011; Newman, Jacobson, & Castonguay, 2014; Sarris, Camfield, & Berk, 2012).

Clients' motivation and expectations were also viewed as between sometimes and often interfering with treatment by 56–76% of respondents. Perceived motivational barriers included little motivation at the outset of treatment and clients' motivation decreasing as they better understood the nature of their OCD. Corroborating these findings, some treatment studies have found poor motivation predicts worse treatment outcomes (Keijsers, Hoogduin, & Schaap, 1994) and less change from psychopharmacological treatment for OCD (Pinto, Pinto, Neziroglu, & Yaryura-Tobias, 2007). However, one study found that pretreatment motivation did not predict treatment outcome (Vogel, Hansen, Stiles, & Götestam, 2006). Nevertheless, no treatment studies have specifically investigated change in motivation during treatment as a moderator of treatment response for OCD symptoms, suggesting that more research is needed. Half the respondents did report using motivational enhancement. Thus, findings from the current study suggest that OCD manuals should incorporate additional motivational techniques beyond what is currently available (Steketee, 1999). Although two studies suggest that motivational interviewing may augment CBT for pediatric OCD or in adults when combined with thought mapping (Merlo et al., 2010; Meyer et al., 2010), another study that was only powered to detect large effect sizes failed to find an augmentation effect (Simpson et al., 2010). Thus, future research should continue to explore the conditions under which motivational interviewing or other means to enhance motivation augment CBT for OCD.

Behaviors of significant others in clients' lives such as family members being controlling and critical also interfered with treatment between sometimes and often (endorsed by 71%). This mirrors findings that paternal rejection is predictive of OCD treatment outcome (Emmelkamp, Hoekstra, & Visser, 1985; Olatunji et al., 2013). Similarly, reinforcement of clients' symptoms and creating dependencies within clients' social environment at least sometimes interfered with treatment (endorsed by 80%). Family accommodations for OCD symptoms negatively predicted outcome in one study (Amir et al., 2000). Likewise, family not supporting the treatment was at least sometimes a barrier (endorsed by 63%), which is similar to findings that the nature of the family environment (e.g., Barrett et al., 2005) and negative

family attributions about OCD symptoms, negatively predicted outcomes (Renshaw et al., 2005). This suggests that in both the empirical literature and in therapists' actual practices, clients' social environments can negatively impact treatment outcomes. This is consistent with a recent meta-analysis suggesting that incorporating clients' family members and significant others augments the impact of OCD treatment (Thompson-Hollands, Edson, Tompson, & Comer, 2014).

Therapists also reported their alliance not being strong enough, therapists' frustration with progress, and negative feelings toward their clients interfered with treatment between never and sometimes. These findings are corroborated by RCTs showing that low therapeutic alliance predicts worse outcomes in CBT for OCD (Keeley, Geffken, Ricketts, McNamara, & Storch, 2011; Simpson et al., 2011; Vogel et al., 2006). Their self-disclosure of issues (especially negative feelings toward clients) may suggest that therapists were forthcoming when responding to this survey. As this may reflect some of their own issues, addressing them in future treatment for OCD may be under the therapists' control to change. Guidelines on how to deal with this issue can be found in Wolf, Goldfried, and Muran (2013).

In regard to limitations of empirically supported treatments, difficulties simulating anxiety-provoking situations in session, and lack of focus on client affect were among the most frequently reported, occurring at least sometimes (endorsed by 49%). However, no studies have examined whether these specific difficulties moderated OCD treatment outcome. Given that in-session exposure is theorized as essential to CBT for OCD, future manuals should attempt to offer guidance for difficulty in these areas. Although these issues were reported less frequently than others within this survey, they may be among the easiest to address while staying within the same cognitive-behavioral framework.

Perhaps one of the most interesting findings from this survey was that 52% of therapists stated that they believed that more than symptom reduction was necessary in OCD treatment. This suggests that when treating clients with OCD most therapists consider outcomes other than symptoms. However, although it is not clear specifically what these therapists consider important, perhaps issues such as quality of life, level of functional impairment, stress level, interpersonal relationships and support, and happiness may be viewed as important. Future research should attempt to explore other areas that therapists feel should be goals in treatment for OCD.

Our results are broadly consistent with results of the surveys for GAD, panic disorder, and social phobia (McAleavey et al., 2014; Szkodny et al., 2014; Wolf & Goldfried, 2014). For example, there was high consistency with other studies on the reported average success rate in reducing symptoms (75% for OCD, 72% in GAD, 78% in panic disorder, and 78% in social phobia). Additionally, of the anxiety interventions not specific to OCD (e.g., psychoeducation and diaphragmatic breathing), most of the interventions were used by a similar percentage of practitioners. This suggests that clinicians perceive some empirically supported treatments to have similar effectiveness across anxiety disorders.

Nonetheless, there were some differences in regard to OCD practices, compared with other anxiety disorders. Specifically, more practitioners endorsed including motivational interviewing for OCD than for other anxiety disorders (17–21% more frequently than other anxiety disorders). That more practitioners endorsed adding motivational interviewing to OCD treatments is interesting, given that minimal motivation at the outset was among the most frequently reported issue across all of the anxiety disorders, as well as mixed findings with respect to whether motivational interviewing augments OCD treatment (Merlo et al., 2010; Meyer et al., 2010; Simpson et al., 2010).

On the other hand, OCD practitioners less frequently included aspects of CT in their treatments compared with reports for other anxiety disorders (cognitive restructuring was used by 10–15% less; assigning cognitive homework was endorsed by 12–14% less in the current sample compared to what was reported for other anxiety disorders). These differences may suggest that OCD practitioners perceive such beliefs as less important to OCD treatment.

Although this is the first study to obtain feedback from practicing clinicians about their experiences in practicing CBT for OCD, there are limitations. For example, therapists in this sample may not be representative of therapists as a whole. All therapists who responded had tried to use CBT for OCD at least once, and although there was quite a range in experience, most respondents identified as either primarily cognitive or primarily behavioral in their orientations. Most therapists also had a Ph.D. Given this, future work should attempt to determine if the reported experiences generalize to therapists with other degrees (e.g., masters' degrees), with less experience, or who identify with other orientations more strongly. Additionally, even though the questionnaire used in this study asked about the frequency of problems that occurred within therapy, as opposed to asking yes/no questions as was done in our previous research (McAleavey et al., 2014; Szkodny

et al., 2014; Wolf & Goldfried, 2014), it did not assess the impact these issues have (i.e., although a comorbid psychosis diagnosis may be rare, it may have a profound impact on treatment). Further, although dimensional scores were used to assess the frequency of limitations to OCD treatment, we did not ask therapists to rate the extent to which they practiced therapeutic techniques (only reporting that they did or did not practice a technique). Having this information is important as it may affect treatment outcomes. For example, a dimensional scale would be able to capture whether therapists used full or partial response prevention, each of which have significantly different treatment outcomes (Abramowitz, 1996). Future studies should examine the impact of the factors that interfere with treatment, as discussed above. Also, it would be important to test empirically the extent to which perceived barriers are true barriers in practice settings.

Conflict of Interest Statement

The authors declare that there are no conflicts of interest.

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