Title: Working with Interpretations in CBT for OCD

Dr Gazal Jones
Royal Holloway, University of London
Egham Hill
Egham, Surrey TW20 0EX

Dr Abigail Wroe
Royal Holloway, University of London
Egham Hill
Egham, Surrey TW20 0EX

Ms Georgina Jefferys
Berkshire Healthcare NHS Foundation Trust
Fitzwilliam House
Skimped Hill Lane, Bracknell
RG12 1BQ

Ms Lucy Jezard
Berkshire Healthcare NHS Foundation Trust
Fitzwilliam House
Skimped Hill Lane, Bracknell
RG12 1BQ

Dr Gary Brown
Royal Holloway, University of London
Egham Hill
Egham, Surrey TW20 0EX

Running head:  Working with Interpretations in CBT for OCD

Key words: interpretations of intrusions, obsessive-compulsive symptoms, clinician views

**Abstract**

**Background**: Cognitive behavioural therapy (CBT) is a highly effective treatment for Obsessive Compulsive Disorder (OCD). Identifying, challenging and monitoring interpretations of intrusions is considered a key element of CBT for OCD but preliminary research suggests that treatment does not always include modification of misinterpretations.

**Aims**: The present investigation explored clinicians’ views on key elements of CBT for OCD to determine whether identifying and modifying key interpretations were considered important in therapy and whether clinicians who do not have specific expertise in OCD found working with interpretations difficult.

**Method**: Study 1 used a qualitative approach to investigate ‘OCD expert’ and ‘non-OCD expert’ clinicians’ views on key elements of CBT for OCD. Study 2 used a questionnaire to investigate what ‘non-OCD experts’ viewed as important and difficult aspects of CBT for OCD.

**Results**: Study 1 results showed that OCD experts and non-OCD experts reported working with interpretations was a key element of CBT for OCD. Study 2 results showed that non-OCD expert rated interpretations as both important and difficult to work with but no more important or difficult than other key elements of CBT for OCD. OCD experts link these interpretations more closely to a formulation and use more techniques when working with interpretations

**Conclusions**: Clinicians who are not expert in OCD may benefit from additional training on working with interpretations, and the use of tools in identifying, monitoring and challenging interpretations of intrusions.

**Introduction**

Cognitive behavioural models of Obsessive-Compulsive Disorder (OCD) highlight the importance of interpretations of intrusions in the development and maintenance of obsessive-compulsive symptoms (Salkovskis 1985; 1989; Wilhelm & Steketee, 2006). Correlational and experimental research findings show a link between interpretations of intrusions and obsessive-compulsive symptoms (Obsessive Compulsive Cognitions Working Group, 1997; 2003, Salkovskis et al., 2000; Bouchard, Rheaume & Ladouceur, 1999; Lopatka & Rachman, 1995). Recent research also shows that reduction in obsessive-compulsive symptoms is associated with changes in interpretations of intrusions (Solem et al., 2015). In line with this, treatment manuals and the Centre for Outcome Research Effectiveness (CORE) competencies report the identification, challenging and monitoring of idiosyncratic interpretations of intrusions as a key element of CBT for OCD (Roth & Pilling, 2007; Whittal & McLean, 1999; Wilhelm & Steketee, 2006).

The introduction of the ‘No Health Without Mental Health’ strategy (Department of Health, 2011) has resulted in increased provision of evidence-based psychological treatments in primary care settings. The stepped care model in the UK, involves clients being offered the least intensive treatment in primary care and only being referred onto specialist OCD services if they do not have an adequate response to lower intensity treatment (NICE, 2005). This model has increased the availability of CBT and led to OCD being predominantly treated by primary mental health clinicians with general training in protocols of depression and anxiety disorders but no specific expertise in OCD. Clinicians in primary care and specialist services are likely to vary in their training and this may impact clinical practice. There are preliminary research findings suggesting that the delivery of CBT for OCD may vary depending on the therapist's’ theoretical orientation and skill. For example, Stobie and colleagues (2007) focused on client experiences and carried out a pilot study on treatment histories of individuals of OCD. They found that 40 per cent of participants who were provided CBT did not receive treatment meeting minimum criteria for adequate CBT.  The researchers found that participants did not do exposure exercises or homework and spent majority of the sessions either speaking freely or about their childhoods. Moreover, they found that only 36 per cent of participants reported having modified misinterpretations in CBT for OCD. Stobie and colleagues (2007) suggested that differences may be due to highly skilled clinicians devising highly idiosyncratic formulations and related intervention plans compared to clinicians with less expertise or skills. Research in fields other than OCD support the notion that highly skilled clinicians or experts develop higher quality formulations and intervention plans (Eells et al., 2005; Dudley et al., 2015).

It has been proposed that a key aspect of CBT for OCD is the identification and modification of interpretations of intrusions and highly idiosyncratic formulations.  However, the reviewed research suggests that therapist views of, and competences in, aspects of therapy may differ depending on experience and training (e.g., Stobie et al., 2007; Dudley et al., 2015). No previous research has explored similarities and differences between clinicians with differing expertise in OCD in their views on clinical practice with OCD. Clinicians views in primary care services and specialist services are particularly relevant today as OCD is treated using a stepped care model and views on key elements of therapy may therefore vary across clinicians. Therefore, the present study aimed to, firstly, identify key aspects of therapy as noted by clinicians working in specialist OCD services (hereinafter referred to as OCD-expert clinicians), and to compare this with views of primary care clinicians (hereinafter referred to as non-OCD expert clinicians) and secondly, to systematically quantify primary care clinicians' views on the importance and ease of a range of clinical aspects, noted by OCD experts as key to CBT for OCD. It was hoped that the above aims would improve understanding of primary care clinicians’ views of and perceived confidence in implementing CBT for OCD and provide important insight into key elements of current clinical practice, common challenges and possible areas of support for primary care clinicians.

Learning objectives of the present paper:

* A key element of CBT for OCD is the identification and modification of idiosyncratic interpretations of intrusions, as recognised by research experts and treatment manuals.
* The increase in CBT provision in primary care services has led to CBT for OCD being predominantly delivered by primary care services, by clinicians who do not have specific specialism or expertise in OCD.
* Research suggests delivery of therapy may vary depending on experience and expertise. To date, there has been no research on OCD expert clinicians (clinicians working in specialist services) and non- OCD expert (clinicians working in primary care settings) views on key elements of CBT for OCD, and whether clinicians consider working with interpretations of intrusions important and/or difficult. The present study aimed to address this gap to improve our understanding of primary care clinicians’ views of and perceived confidence in implementing CBT for OCD.

**Method**

Previous studies investigating therapist views on therapy have employed two methodologies: semi-structured interviews or questionnaires (e.g., Kroese et al., 2014, Naeem et al., 2010; Morrison & Barratt, 2010; De Haan & Lee, 2014). The present investigation used both semi-structured interviews and questionnaires in exploring OCD expert and non-OCD expert views on the key elements of CBT for OCD.

Local approval was gained from the Healthcare NHS Foundation Trust Research and Development Department to recruit staff members within Improving Access to Psychological (IAPT) services in the trust.

**Study 1**

**Design.** Study 1 involved a qualitative thematic analysis approach to exploring therapists’ views on the key elements of CBT for OCD. Thematic analysis is a method used to identify, analyse, and report themes within data (Braun & Clarke, 2006). Thematic analysis was favoured for the present study above other approaches as the main aim was to establish whether participants’ views were influenced by their CBT practice, to explore similarities and differences across participant groups and analyse data from a realist as opposed to interpretative approach. The researcher held a realist position where the participants’ language was regarded as reflecting the meaning and experience of the phenomenon under investigation (Widdicombe & Wooffitt, 1995).

**Participants.**
Six OCD expert clinicians agreed to participate in the study. OCD experts were approached to explore views of clinicians with extensive experience of working with OCD clients and within specialist OCD settings. Experts in the field were labelled as ‘OCD experts’ if (i) they had extensive clinical experience in CBT for OCD (e.g. more than three years), (ii) were currently working in or had experience of working in specialist OCD clinics and, (iii) had peer reviewed publications in OCD. The OCD experts consisted of four females and two males aged between 38 and 45 years. The OCD expert participants had three to ten years of experience working with OCD clients following Clinical Psychology training.

Six non-OCD expert clinicians (High Intensity therapists), four females and two males, aged between 28 and 48 years agreed to participate in the study. The therapists had between two and 15 years of experience following High Intensity (HI) training, and had all worked with OCD during their time as a qualified therapist, but not had any extra specialist training or supervision in OCD.

**Procedure.**

***Initial interview schedule.*** The initial interview schedule was sent to a Clinical Psychologist working in a primary care service for feedback. The feedback suggested that the schedule was clear and succinct. No changes were therefore made to the initial interview schedule.Two pilot interviews were carried out prior to recruitment; one with an OCD expert and one with a primary care practitioners (a ‘High Intensity’ therapist). Feedback from these interviews was used to devise instructions, and a question on challenges of working with clients with OCD was added.

***Interview procedure and transcription.*** The interviews were carried out over the telephone with all participants, after participants read the information sheet and completed the consent forms. The interviews lasted approximately 30 minutes. Each interview was transcribed verbatim by the researcher and did not include non-verbal utterances and pauses. To maintain anonymity, clinicians were given participant numbers.

***Analytic strategy.***

*Stages of thematic analysis.* The study followed the three stages of thematic analysis outlined by Braun and Clarke (2006): i) the researcher read and re-read the transcripts during transcription to familiarise themselves with the depth and content of the interviews; ii) the researcher generated an initial thematic coding frame by organising chunks of data into meaningful categories; and iii) the researcher reviewed, defined and named themes by contrasting them with previous themes.

*Validity.* A Trainee Clinical Psychologist developed a separate coding frame based on a random selection of 20 passages from all transcripts. This coding frame was compared to the main researcher’s and overlap and lack of overlap was discussed.

**Results**

The final thematic coding frame was organised into three main themes. These themes were further divided into two or four subthemes (see Table 1).

(INSERT TABLE 1 ABOUT HERE)

*Theme 1: Identifying key cognitions.* Participants described the importance of identifying key cognitions using three approaches: (i) developing an idiosyncratic formulation, (ii) using recent examples, (iii) employing CBT techniques and, (iv) administering questionnaires.

*Subtheme: Idiosyncratic formulation*. Participants spoke about the importance of having a ‘shared’ and ‘idiosyncratic’ understanding of the client’s key cognitions within a formulation. All participants explained that they used cognitive-behavioural formulations to identify key cognitions. OCD experts explained that they used Salkovskis’ (1985; 1989) cognitive-behavioural model. The majority of HI therapists explained that they used Steketee and Wilhelm’s (2006) cognitive behavioural model. Participants described that the idiosyncratic formulation consisted of two components: (i) the interpretation, appraisal or meaning associated with intrusive thoughts and, (ii) the maintenance cycles. Participants described the importance of bringing these two components to the client’s awareness.

The shared formulation should be… idiosyncratic to them, so, it should feel like it’s a really personalised… explanation of what is happening for them, when they get anxious...the really key thing about it is that it has the maintenance cycles, so it should help them to see that what they’re doing. (OCD Expert 3)

“The key for me… the space between the intrusion and the appraisal, helping the client to see that… they’re applying meaning to having the, the intrusion in the first place”. (HI therapist 4)

*Subtheme: Recent examples.* Four OCD experts spoke about exploring a recent example where anxiety had been triggered to identify key idiosyncratic cognitions that were maintaining the client’s obsessive-compulsive symptoms. Participants’ accounts suggested this was a useful technique in identifying intrusive thoughts and associated interpretations. For instance, HI therapist 3 explained that:

We might just look at a recent situation…then we try to pick up…the intrusive thought, try and look at perhaps any assumptions they might have had, we start to look at the appraisals they might have had as well.

*Subtheme: CBT techniques.* All participants spoke briefly of a range of CBT techniques they used with clients to identify key interpretations. All participants described two key techniques in this subtheme: downward arrowing and Socratic dialogue. For instance, OCD Expert 1 explained: “you might use stuff like, downward arrow or so on to get people to kind of, identify specific things which are at the bottom of it”.  Participants also spoke about the usefulness of Socratic dialogue in eliciting the key interpretation for the client: *“*So, a lot of which is Socratic questioning, like asking the client for what the meaning is to them or what happens next” (HI therapist 1).

*Subtheme: Questionnaires.* OCD experts spoke about using diagnostic and cognition questionnaires to identify key thoughts and beliefs. All HI therapists explained that they exclusively use the OCI as the OCD questionnaire in their work as it is a service requirement.

The Y-BOCS checklist which will just sort of give you an overview of kind of what people are like experiencing and… like the responsibility attitudes questionnaire, that you would use to look at, the second level of thoughts. (OCD Expert 1)

One OCD expert spoke about developing idiosyncratic questionnaires to capture the idiosyncrasies in their client’s difficulties alongside the use of standardised questionnaires:

“For some I would develop idiosyncratic measures… we would kind of figure out what the belief was and get a rating of that belief so it’s not total measures. But I also of course use total measures…the OCI of course…the Y-BOCS.” (Expert 6)

Overall, the main theme of the role of idiosyncratic cognitions highlighted the importance of identifying key intrusive thoughts and interpretations in CBT for OCD. All participants reported that idiosyncratic formulation and CBT techniques supported them in identifying idiosyncratic cognitions.

*Theme 2: Challenging cognitions*. Participants described two approaches to challenging client cognitions: (i) identifying a less threatening alternative and, (ii) using behavioural experiments.

*Subtheme: Less threatening alternative.* Three OCD experts spoke about the importance of supporting the client in identifying a less threatening alternative. OCD Expert 2 for instance explained that the therapist’s task was to “help people develop a less threatening understanding of why these thoughts are occurring and to normalise the kind of thoughts that they have”. OCD experts spoke particularly about using the Theory A and Theory B framework very early in therapy to help clients develop a less threatening alternative.

HI therapists did not report developing a less threatening alternative using the Theory A and Theory B framework. However, HI therapists spoke about the importance of normalising client experiences. HI therapists also described using a range of cognitive challenging techniques such as thoughts records, responsibility pie charts and continuums to challenge the threatening cognitions.

Generally using thought diaries are helpful, in getting them to write them (interpretations) down and challenge them. I guess the responsibility pie chart can often be really helpful with OCD coz often there is that overinflated sense of responsibility. (HI therapist 7)

*Subtheme: Behavioural experiments.* All participants spoke about the importance of behavioural work and of doing behavioural work as early on in the intervention as possible. Participants described the link between behavioural experiments and formulation by explaining that: “it is translating their (service user’s) new understanding into action” (OCD Expert 2).

Several HI therapists discussed using behavioural experiments as a method of challenging idiosyncratic cognitions and spoke about behavioural experiments as being separate from their cognitive work.

To help them challenge those beliefs and the question we’re asking is ‘does having a bad thought makes me a bad person’ basically. And once we’ve worked on that, it’s straight for behaviours, behaviour work and working on stopping the reassurance, mental rituals. (HI therapist 2)

OCD experts spoke about combining cognitive and behavioural work by using behavioural experiments within a Theory A and Theory B framework.  For instance, OCD Expert 3 explained:

We would get a belief rating for Theory A and Theory B at the beginning…and...if we were doing behavioural experiments, we would get a belief rating for whichever belief it was that we were particularly testing out with that.

Overall, all participants described that they challenged key cognitions throughout therapy. There were differences in the approaches OCD experts and HI therapists used to address key cognitions. OCD experts described that the service user’s Theory A and B, which were identified early on in therapy, continued to inform the basis of challenging cognitions in their work and HI therapists addressed key cognitions using a range of cognitive techniques and behavioural experiments.

*Theme 3: Monitoring shift in cognitions.* All participants explained that they monitored shift in cognitions by tracking idiosyncratic cognitions throughout treatment. OCD experts discussed this within the Theory A and Theory B framework, and HI therapists discussed capturing shift in cognitions following behavioural experiments and by using thought diaries. OCD experts also explained that they used questionnaires to monitor shift in cognitions.

*Subtheme: Belief ratings.* Four OCD experts spoke about monitoring shifts in idiosyncratic cognitions they had identified when devising a Theory A and Theory B. They explained that they monitored belief ratings regularly throughout therapy. OCD Expert 4’s response best encapsulated how these ratings were used:

I guess that would be through what I was just saying in terms of Theory A and B, so we would take kind of a Theory A and B rating. So the extent to which the person feels that those thoughts mean that they are bad, dangerous, bad person versus these are just mental junk, random thoughts that all of us can have... That would be kind of captured I guess in their theory, sort of idiosyncratic Theory B that we would kind of draw up and we would kind of take a rating of that, so regularly.

HI therapists explained that they used several ways to monitor idiosyncratic cognitions throughout therapy. These included thought diaries, reviewing the formulation and reviewing goals. HI therapists also described using belief ratings in thought diaries and behavioural experiments.

OCD experts monitored changes in idiosyncratic cognitions by asking clients to rate their Theory A and Theory B throughout treatment. All OCD experts explained that these cognitions were monitored regularly, often session by session. HI therapists monitored changes in idiosyncratic cognitions by using belief ratings in thought diaries and before and after behavioural experiments.

*Subtheme: Questionnaires.* Three OCD experts spoke about using questionnaires to monitor shift in cognitions. These included questionnaires such as the Responsibility Attitudes Scale (RAS) and Responsibility Interpretations Questionnaire (RIQ; Salkovskis et al., 2000). OCD experts explained that they asked clients to complete questionnaires at regular intervals and then compared ratings over time to see if any progress has been made or if anything still needs addressing.

So the RAS and the RIQ we would use it at the beginning, middle and end of treatment basically, so at Session 6, which is in theory at the middle of treatment, we would use that to check that things are coming down. (OCD Expert 3)

OCD experts used questionnaires to monitor shift in cognitions. The questionnaires allowed them to identify areas that needed further intervention and also gave them the opportunity to select specific highly rated items from the questionnaires to address in intervention.

Within this main theme, all participants described monitoring shift in cognitions. HI therapists monitored the shift using belief ratings and cognitive challenging techniques, with OCD experts also using questionnaires.

**Study 2**

**Design.** Study 2 involved participants completing a questionnaire developed by the researchers. The questionnaire was devised using the key elements of therapy mentioned in Study 1 and the key elements of therapy listed in the CORE competencies for CBT for OCD (Roth & Pilling, 2007; Whittal & McLean, 1999; Wilhelm & Steketee, 2006). The questionnaire consisted of 14 questions focused on elements of CBT for OCD (see appendix for full questionnaire) and five control items involving elements of CBT for other disorders. Control items were included to identify whether participants rated non-OCD relevant competences as highly as OCD relevant competences. Participants rated the ‘importance’ and ‘difficulty’ of the items using a 5-point Likert scale (1 = not important at all - 5 = very important; 1 = extremely easy -  5 = extremely difficult).

**Participants and procedure.** Participants were recruited from the local IAPT services.Participants included HI therapists; HI therapists are trained in providing protocol based CBT for anxiety and depressive disorders and will be referred to as non-OCD experts throughout this paper.18 HI therapists completed the questionnaire on Survey Monkey (webpage). The participants consisted of 3 males and 15 females, aged between 28 and 48 years. Participants had experience of providing CBT for OCD to an average of 5-20 clients within a given year in the IAPT service. Two participants were excluded as they did not have experience of working with at least five clients with OCD.  The final sample consisted of 16 HI therapists.

**Statistical Analyses.** SPSS (Version 17.0) was used to analyse the data (SPSS Inc., 2008). There was no missing data. Preliminary examination of the data showed that non-parametric analyses were appropriate. Descriptive data was calculated for each item and items were ranked from most to least important and from most to least difficult using mean ratings (see Tables 2 and 3) and the Friedman test was carried out to see if there was a significant difference between top five ranked items. Wilcoxon signed-rank tests were used to compare OCD and non-OCD items (reverse items) for importance and difficulty ratings.

**Results.**

**Aspects of therapy rated as most important.** Five aspects of therapy rated as most important were selected using mean ratings.The mean ratings suggested that ‘use of behavioural experiments to test maladaptive beliefs/meaning/interpretations’ was rated as the most important element of therapy (*M* = 5, *SD* = 0), followed by ‘developing a collaborative formulation’ (*M* = 4.75, *SD* = 0.45), ‘setting achievable goals’ (*M* = 4.69; *SD* = 0.70), ‘including idiosyncratic beliefs / meanings / interpretations of intrusions in a formulation’ (*M* = 4.63, *SD* = 0.89) and ‘asking about idiosyncratic beliefs/meanings/interpretations of intrusions during assessment’ (*M* = 4.56, *SD* = 0.89). There was no significant difference between importance ratings on the top five rated items, X2(4) = 5.10, p >.05.

**Aspects of therapy rated as most difficult.** Five aspects of therapy rated as most difficult were selected using difficulty ratings.The difficulty ratings suggested that ‘modifying idiosyncratic beliefs/meanings/interpretations of intrusions’ was rated as the most difficult element of therapy (*M* = 3.44, *SD* = 1.15), ‘using behavioural experiments to test maladaptive beliefs/meanings/interpretations’ (*M* = 3.12; *SD* = 1.20), ‘exposure and response prevention’ (*M* = 3.13, *SD* = 1.20), ‘asking about idiosyncratic beliefs/meanings/interpretations of intrusions during assessment’ (*M* = 2.94, *SD* = 1.00) and ‘systematically monitoring ratings of idiosyncratic beliefs/meanings/interpretations of intrusions regularly throughout therapy’ (*M* = 32.81, *SD* = 1.28). There was no significant difference between difficulty ratings for the top five rated items, X2(4) = 2.29, p >.05.

(INSERT TABLES 2 & 3 ABOUT HERE)

**Difference between OCD and control items.**

*Importance.* There was a significant difference in importance ratings for OCD and non-OCD (control) items, Z = -3.52, p < .001. Median ratings were higher for OCD items (*Mdn* = 4) compared to non-OCD (control) items (*Mdn* = 2.9).

*Difficulty.* There was no significant difference in difficulty ratings for OCD and non-OCD (control) items, Z = -1.06, p > .05. Median ratings were the same for OCD and non-OCD items (*Mdn* = 2.9).

**Discussion**

The present investigation is the first to explore clinician views on CBT for OCD using both qualitative and quantitative approaches. The investigation aimed to better understand OCD expert and non- OCD expert clinician views on working with interpretations of intrusions in CBT for OCD. The results broadly supported the notion that OCD experts and non-OCD experts consider interpretations of intrusions a key element in CBT for OCD, and further analyses helped clarify non-OCD expert clinicians’ views on working with interpretations of intrusions.

The results of Study 1 showed thatall participants described identifying, challenging and monitoring idiosyncratic interpretations throughout treatment. This is in line with recent findings that cognitions are important in CBT for OCD alongside behavioural approaches such as Exposure and Response Prevention (e.g., Whittal et al., 2008). OCD experts and non-OCD expert clinicians differed in the techniques and tools they used to target idiosyncratic interpretations throughout therapy. OCD experts reported more techniques (e.g., Theory A and Theory B), placed greater emphasis on the idiosyncratic nature of cognitions in CBT for OCD and linked their formulation to specific techniques. This finding is consistent with previous research reporting that experts produce better quality formulations (Eells et al., 2005), show greater parsimony and choose more relevant treatment options compared to non-OCD expert clinicians (Dudley et al., 2015).

The qualitative analyses also suggested that OCD experts and non-OCD experts used different cognitive-behavioural formulation models, with OCD experts using Salkovskis’ (1985; 1989) and non-OCD experts using Steketee and Wilhelm’s (2006) cognitive-behavioural formulation. The difference in use of formulation models may be due to differences in training backgrounds or may reflect preference of difference formulation models within different services. Despite differences in use of formulation models, all participants reported identifying, challenging and monitoring interpretations of intrusions are key elements of CBT for OCD and identified a range of techniques such as a shared formulation, downward arrow, Socratic dialogue, Theory A/Theory B, behavioural experiments and questionnaires when working with interpretations of intrusions.

The results of Study 2 indicated that non OCD-expert clinicians generally ranked activities involving beliefs/meanings/interpretations of intrusions as most important and most difficult in CBT for OCD. The five top items rated as most important, however, included two general CBT skills not exclusively linked to CBT for OCD (i.e., ‘developing a collaborative formulation’ and ‘setting achievable goals’) whereas, items rated as most difficult involved work with beliefs/meanings/interpretations of intrusions. There was no difference in importance and difficulty when the top-rated difficulty items were compared with one another. This may be due to the conceptual overlap between these items as they can all be related to cognitions in OCD.

Non-OCD expert clinicians correctly rated OCD items as most important in CBT for OCD. This suggests non-OCD expert clinicians are aware of OCD specific elements of therapy and are able to differentiate these from elements more relevant to CBT for other disorders (e.g., behavioural activation in CBT for Depression).

Non-OCD expert clinicians’ ratings did not differ from OCD to non-OCD items, suggesting the OCD related elements of CBT were perceived as no more difficult than non-OCD related elements of CBT. It may be the case that due to training in common disorders (e.g., Depression, Generalised Anxiety Disorder), non-OCD expert clinicians perceive elements across therapies as equally difficult to implement.

There were several limitations in the present investigation: (i) most interviews were carried out on the telephone; (ii) small sample size for participants completing the questionnaire; (iii) participants may have detected the researchers aims as several of the items on the questionnaire included cognitions in OCD, and (iv) participants may not have felt comfortable reporting elements of therapy they found difficult as this may reflect poorly on their ability or skill.

The present investigation used qualitative and quantitative approaches to understanding OCD expert and non-OCD expert views on their clinical practice with OCD clients. The findings indicate that teaching and training of non- OCD expert clinicians in Primary Mental Health services is resulting in good knowledge on the key elements of CBT for OCD. However, OCD experts report linking idiosyncratic interpretations more closely to their formulation and use additional techniques compared to non-OCD experts. OCD has a reputation of being difficult to treat (Fenske & Schwenk, 2009)and due to limited resources cannot be treated by experts alone. Further training and time effective tools that facilitate identification and challenging of interpretations of intrusions may therefore be particularly useful in primary care settings. Additional research is needed with primary mental health clinicians’ perceived difficulties in implementing CBT for OCD to fully assert that they do not perceive working with beliefs/meanings/interpretations of intrusions as a challenging element of CBT for OCD. **Summary of main points**

* The qualitative study showed that OCD experts and non-OCD experts report identifying, monitoring and challenging interpretations as a key aspect of CBT for OCD. OCD experts report more instances of linking interpretations to formulations and using interpretation specific CBT techniques than non-OCD experts.
* The quantitative analyses showed that non-OCD experts report working with interpretations as both important and difficult. However, they do not report these to be more important or difficult than other key elements of CBT for OCD (e.g., ERP).
* It may be helpful for non-OCD expert therapists to have further training in working with interpretations of intrusions, particularly implementing techniques and questionnaires.
* Further research into primary mental health clinicians’ perceived difficulties in implementing CBT for OCD is needed to fully understand challenges they may face when working with interpretations of intrusions.
* Suggested follow-up reading:

**Solem S, Hagen K, Hansen B, Ashild T, Launes G, Lewin AB, Storch EA, Vogel, PA** (2015). Thought content and appraisals in cognitive behavioural therapy for Obsessive-Compulsive Disorder. *Journal of Cognitive Psychotherapy,* **29(2),**106-115.

**Stobie B, Taylor T, Quigley A, Ewing S, Salkovskis PM** (2007). “Contents may vary”: A pilot study of treatment histories of OCD patients. *Behavioural and Cognitive Psychotherapy*, **35,** 273–282.

**References**

**Bouchard C, Rheaume J, Ladouceur R** (1999). Responsibility and perfectionism in OCD: An experimental study. *Behaviour Research and Therapy* **37,** 239–248.

**Braun V, Clarke V** (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, **3(2),** 77–101.

**De Haan BKL, Lee CW** (2014). Therapists’ thoughts on therapy: clinicians’ perceptions of the therapy processes that distinguish schema, cognitive behavioural and psychodynamic approaches. *Psychotherapy Research* **24(5),**538 – 549.

**Department of Health** (2011). *No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages.* London: Author.

**Dudley R, Ingham B, Sowerby K, Freeston M** (2015). The utility of case formulation in treatment decision making; the effect of experience and expertise. *Journal of Behavior Therapy and Experimental Psychiatry* **48,** 66 – 74.

**Eells TD, Lombart KG, Kendjelic EM, Turner CL, Lucas CP** (2005). The quality of psychotherapy case formulations: A comparison of expert, experienced, and novice cognitive-behavioral and psychodynamic therapists. *Journal of Consulting and Clinical Psychology*, **73(4),** 579 - 589.

**Fenske JN, Schwenk TL** (2009). Obsessive-Compulsive Disorder: Diagnosis and Management. *American Family Physician,* **80(3),** 239 - 245.

**Kroese BS, Jahoda A, Pert C, Trower P, Dagna, D, Selkirk M** (2014). Staff expectations and views of Cognitive Behaviour Therapy (CBT) for adults with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities,* **27(2),** 145 – 153.

**Lopatka C, Rachman S** (1995). Perceived responsibility and compulsive checking: an experimental analysis. *Behaviour Research and Therapy*, **33,** 673–684.

**Morrison AP, Barratt, S** (2010). What are the components of CBT for psychosis? A Delphi study. *Schizophrenia Bulletin,* **36(1),** 136 – 142.

**Naeem F, Gobbi M, Ayub M, Kingdon, D** (2010). Psychologists experience of cognitive behaviour therapy in a developing country: A qualitative study from Pakistan. *International Journal of Mental Health Systems,* ***4*(2),** 1-9.

**NICE** (2005). *Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment*. Retrieved from http://www.nice.org.uk/CG31

**Obsessive Compulsive Cognitions Working Group** (1997). Cognitive assessment of obsessive-compulsive disorder. *Behaviour Research and Therapy*, **35,** 667–681.

**Obsessive Compulsive Cognitions Working Group** (2003). Psychometric validation of the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory: Part I. *Behaviour Research and Therapy*, **41,** 863–878.

**Roth AD, Pilling S** (2007). *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders*. London: Department of Health.

**Salkovskis PM** (1985). Obsessive-compulsive problems: A cognitive-behavioural analysis. *Behaviour Research and Therapy*, ***23*(5),** 571–583.

**Salkovskis PM** (1989). Cognitive-behavioural factors and the persistence of intrusive thoughts in obsessional problems. *Behaviour Research and Therapy*, **27,** 677–682.

**Salkovskis PM., Wroe AL, Gledhill A, Morrison N, Forrester E, Richards C, Reynolds M, Thorpe S** (2000). Responsibility attitudes and interpretations are characteristic of obsessive compulsive disorder. *Behaviour Research and Therapy*, **38(4),** 347–372.

**Solem S, Hagen K, Hansen B, Ashild T, Launes G, Lewin AB, Storch EA, Vogel, PA** (2015). Thought content and appraisals in cognitive behavioural therapy for Obsessive-Compulsive Disorder. *Journal of Cognitive Psychotherapy,* **29(2),**106-115.

**SPSS Inc** (2008). *SPSS Statistics for Windows, Version 17.0*. Chicago, IL: SPSS Inc.

**Stobie B, Taylor T, Quigley A, Ewing S, Salkovskis PM** (2007). “Contents may vary”: A pilot study of treatment histories of OCD patients. *Behavioural and Cognitive Psychotherapy*, **35,** 273–282.

**Whittal ML, McLean PD** (1999). CBT for OCD: The rationale, protocol, and challenges. *Cognitive and Behavioral Practice*, **6(4),** 383–396.

**Whittal ML, Robichaud M, Thordarson DS, McLean PD** (2008). Group and individual treatment of obsessive-compulsive disorder using cognitive therapy and exposure plus response prevention: a 2-year follow-up of two randomized trials. *Journal of Consulting and Clinical Psychology*, **76,** 1003–1014.

**Widdicombe S, Wooffitt R.** (1995). *The Language of Youth Subcultures: Social Identity in Action*. London: Harvester Wheatsheaf.

**Wilhelm S, Steketee G** (2006). *Cognitive Therapy Obsessive-Compulsive Disorder: A Guide for Professionals*. Oakland, CA: New Harbinger Publications.

*Acknowledgements.* We would like to thank all clinicians who kindly gave their time to take part in this research.

*Financial Support.* This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

*Conflict of Interest*. None.

*Ethical Standards*. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional guides on the care and use of laboratory animals.