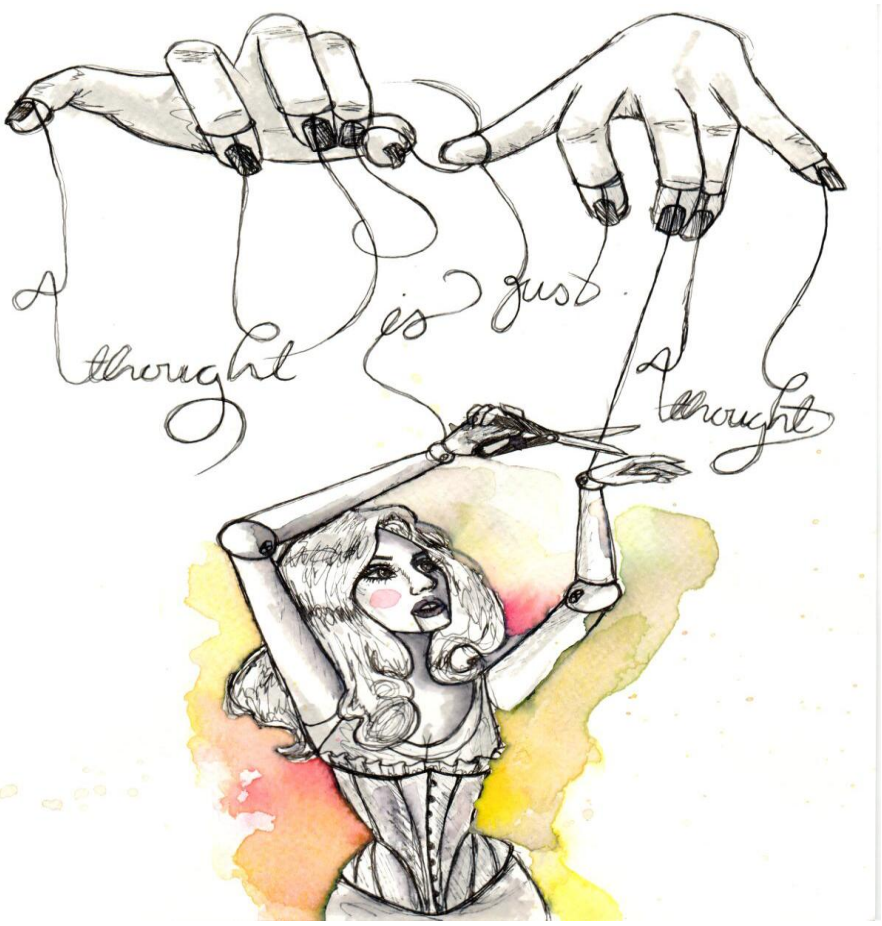
Obsessive Compulsive Disorder

A Self Help Guide



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

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Overview
This booklet is based on Cognitive Behavioural Therapy (CBT) for Obsessive Compulsive Disorder (OCD) involving Exposure and Response Prevention (ERP). This is the psychological approach recommended by National Institute of Health and Clinical Excellence (NICE), a government organisation that advises the NHS: https://www.nice.org.uk

All characters appearing in this work are fictitious. Any resemblance is coincidental.

Acknowledgements
Our thanks also to Dr Ian Hughes, Andy Lodwick, Dr Michael Bates and Tommy Carr (all of Cardiff and Vale University Health Board) for their suggestions and help.

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Chapter One: Introduction

Obsessive Compulsive Disorder (OCD) is an anxiety disorder characterised by obsessive thoughts and physical and/or mental compulsions. It is a common problem but one that can be very disabling for people. The World Health Organisation lists OCD as one of the top ten disabling illnesses in the world.

What are obsessions?

An obsession is a persistent thought, image or urge that triggers distress. These obsessions are frequent, unwanted and difficult to control or get rid of.

Common obsessions include:

- Fear of contamination from dirt, germs, viruses, bodily fluids, faeces, chemicals, dangerous materials
- Fear of being harmed (e.g. doors not being locked)
- Excessive concern with order or symmetry
- Obsessions with body or physical symptoms
- Blasphemous thoughts (e.g. offending God)
- Upsetting sexual thoughts
- Thoughts of violence or aggression

It should also be noted that studies have shown that **all** people experience intrusive thoughts from time to time (for a list of common intrusive thoughts in people *without* OCD, see Handout 1, p.39). However, a person with OCD worries that an intrusive thought is a sign of danger.

What are compulsions?
Compulsions are repetitive behaviours or mental acts that a person feels driven to perform in response to an obsession. Most people with OCD have more than one compulsion.

Often people think something awful will happen if they do not act on their compulsions.

Common compulsions include:

- Checking (e.g. taps, gas, locked doors)
- Cleaning/washing
- Repeating acts
- Ordering or striving for symmetry/ exactness
- Counting

These types of compulsions may be quite noticeable to an observer. However, there are lots of compulsions which can be carried out in a person's head. These are known as mental compulsions (e.g. saying a fixed repetitive prayer, or a certain pattern of words).

Examples of OCD

In the following examples you will hear about different types of OCD. However, you may notice some similarities. In fact, the way that OCD is maintained is fairly similar for everyone who experiences it. This idea will become clearer in Chapter 2: 'What keeps OCD going?'

Angela

Angela works in a nursery. She is troubled by thoughts of being physically violent towards school children. She sees an image of herself stabbing a child. Angela is actually a very caring woman who is no risk to children, but she is constantly troubled by these thoughts and worries that she will 'go mad', lose control and act on them. She tries to block out these thoughts. She also says a rhyme to herself after having a thought in order to 'make the thought good'. She feels better for a short while after, but the thoughts keep coming back. She wonders if she should change jobs before anything 'awful happens'.

Robert

Robert is worried that he may get HIV/ AIDS after touching something that has germs on it. He worries that he may pick up germs on his hands or on his clothing. He also worries that he may come into contact with someone who has not washed properly. He is reluctant to shake hands. He washes his hands hourly and washes his clothes every day. Robert is starting to have problems committing to tasks in work because he is so preoccupied by washing. He has started to avoid going into work and to avoid public places where he, or his clothing, may come into contact with other people.

Clive

Clive is continually troubled by the thought that his house will get burgled. He helps deliver food to elderly people but this is becoming difficult as he repeatedly drives home to check his house is locked. Clive is also finding it difficult to leave the house in the morning as he has to check all windows and doors at least five times. The more he wonders if he really has closed the upstairs window, the more he becomes unsure. Clive's problems are having a negative impact on his relationship with his wife and they have started to row over his checking. He is also spending significant amounts of money on continually upgrading his burglar alarm as he worries it will stop working.

Who develops OCD?
Anyone can develop OCD and it is believed that one in a hundred people has the condition to some degree. Studies have found relatively consistent rates across cultures, although the exact content of obsessions and compulsions differ. There is also no typical mode of onset for OCD: Some people develop it gradually whereas other people develop it suddenly following a particular life experience e.g. onset of illness, loss of a loved one or major financial problems.

What makes someone more vulnerable to OCD?
Although we cannot predict whether someone will develop OCD, there does seem to be several factors that make people more vulnerable to it:

1. A belief about the thoughts we have
Everyone experiences unwanted intrusive thoughts whether they are experiencing OCD or not. The difference with OCD is that we develop a belief that our thoughts have meaning (e.g. 'this is more likely to happen because I've had the thought'), or say something about us as a person (e.g. 'I could be dangerous, or a bad person'). This makes it difficult for someone with OCD to dismiss the thought and more likely to feel they have to do something about it.

Indeed, obsessions often relate to the things that are most important to you as an individual. These thoughts are inconsistent with your view of yourself and are therefore viewed with shame and fear. The idea that these thoughts could be true or have some meaning about what kind of person you are is very upsetting. As a result there is a strong urge to neutralize or keep thoughts secret.

Remember: People who are experiencing intense guilt, anxiety and shame over thoughts are different from those who actually act on them. The history of violent crime is dominated by those who feel no guilt or remorse; the very fact that someone is tormented by intrusive thoughts and has never acted on them before is an excellent predictor that they will not act upon these thoughts.

2. Wanting to be certain

Another problem that helps maintain OCD is wanting to be 100% certain that we have done something (i.e. checked something), or not done something (i.e. not hurt someone). Being unsure, or doubting ourselves often creates anxiety that feels intolerable and we feel the urge to do something about it –i.e. act out compulsions and rituals. We will often repeat the compulsions until we 'feel right' as this reassures us that we have done something well enough. Unfortunately this helps maintain the cycle of OCD, as we will see in Chapter 2.

3. An Increased Sense of Responsibility

People with OCD often feel overly responsible for their actions. They worry that doing something wrong or not doing something (e.g. not checking) will cause some sort of harm. This idea is very hard to tolerate for someone who cares a lot about other people and feeds the belief that it is 'better to be on the safe side'. This is especially hard if you have a past experience when something went wrong and you believe it was your fault.

OCD is a problem likely to be experienced by people who are especially sensitive, caring, responsible, conscientious and have high standards. For example, a number of women report an onset of OCD during pregnancy or soon after the birth of their child. This may be in response to an increased caring response.

A sense of being responsible helps maintain the rituals as it is intolerable to risk the worst happening and risk the feeling of being at fault or *irresponsible*.

OCD and other problems

One half to three quarters of people with OCD also experience additional problems. For example:

- Depression often occurs in response to the persistent and debilitating effects of OCD
- People with OCD can also experience social anxiety – i.e. a fear of being negatively judged by others.

Can intrusive thoughts ever be helpful?

People with OCD are often concerned with getting rid of intrusive thoughts. However what would life be life without such thoughts? It is a sign of a good imagination and creativity. What inventions, songs, pictures wouldn't have been created without an intrusive thought?

Trying to overcome OCD is therefore not about getting rid of intrusive thoughts but learning how to resist the rituals that fuel your OCD.

Summary

1. OCD is characterised by unwanted thoughts (i.e. obsessions) that the person tries to 'neutralise' through certain actions (i.e. compulsions)
2. All people experience intrusive thoughts. However, people with OCD worry that the intrusive thought is a sign of danger.
3. OCD is a common problem that exists across cultures
4. OCD thoughts often conflict with a person's values and sense of identity, leading to feelings of shame and fear.
5. Wanting to be certain, an increased sense of responsibility and a belief about thoughts (e.g. signalling danger) all increase the risk of developing OCD

Chapter 2: What keeps OCD going?

'The way you have understood your OCD so far and the solutions you have applied, may well be the cause of your problem, actually by keeping it going'

There is some disagreement about what makes someone vulnerable to OCD but there is a lot of agreement about what keeps it going. Breaking out of these cycles is crucial to overcoming OCD.

In order to think about how OCD is maintained let us have a think about Robert. Each point below relates to the numbers on Figure 1:

1. Robert sees a stain on the floor. We call this the *Trigger.*

2. The trigger causes an *Intrusive thought*. Eg. 'Is that blood?'; 'Am I contaminated with HIV/AIDS?'

3. *Interpretation*: Robert interprets the intrusive thought as a sign of danger: 'This is a thought I cannot ignore – it means I am in real danger'

4. *Responsibility for Action*: Robert thinks to himself: 'Because there is danger, I must protect myself and/or others!'

5. *Safety Behaviours*: Robert feels compelled to wash his hands and seek reassurance.

6. The cycle repeats - Robert's safety behaviours only reduce anxiety and doubt temporarily:
   - Robert thinks: 'I am safe because I washed my hands'. However, this prevents him realising that nothing would have happened anyway
   - Robert asks others for reassurance. However, this only makes him feel less certain about whether he spotted blood, or not.

In addition:

7. Feelings and behaviours feed into each other. Robert performs his cleaning to feel ‘safe’ and counteract the danger. However, carrying out safety behaviours can also be very tiring and this exhaustion can amplify feelings of stress and fear.
8. Feelings of anxiety can also trigger the intrusive thought to re-occur. Your brain may rationalise that, as you are feeling all these mental and physical side effects of anxiety, there must be a real danger present. For example, Robert may think that ‘feeling this bad must mean that my thoughts about being contaminated are real’ (see arrow 8, Fig.1).

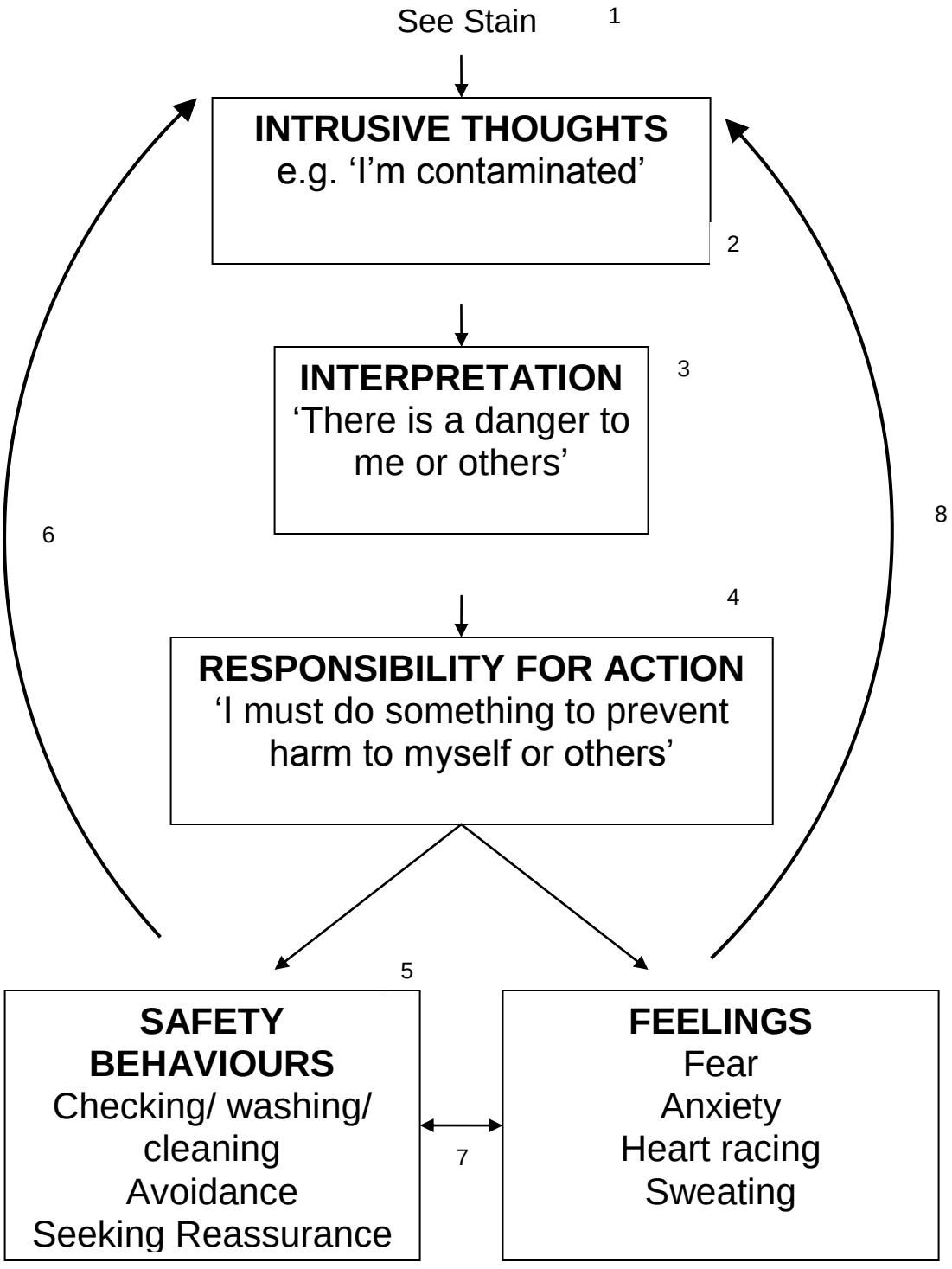

Figure 1: The Vicious Cycle of OCD

Interpretation of thoughts

Almost everyone experiences some kind of intrusive thought or urge of some kind at some point in their lives. For example, someone may have the fleeting thought of running their car off the road. However, someone with OCD cannot ignore such thoughts and sees the thought or the situation as dangerous.

A person **without** OCD sees an intrusive thought as 'just a thought': They are able to dismiss intrusive thoughts as non-important and so break the cycle at this point. However, a person with OCD interprets an intrusive thought as dangerous. They may think that having the thought of running the car off the road will mean they will act on this.

Look again at Figure 1: Robert has the thought that he is contaminated with a sexually transmitted disease. Such fleeting thoughts are common in people *without* OCD (see Handout 1, p.39). However, Robert cannot dismiss this thought and feels that he is in real danger. Indeed, this process may happen so quickly that he may be unaware of how he has interpreted his thoughts!

Sometimes the sense of danger is immediate: 'I may pick up a knife and harm my baby'. Sometimes the danger is far in the future: 'If I touch this, I may contract a deadly disease at a later date'.

Sometimes having a thought makes people think ‘Have I carried out the action/event that I had been thinking about’. This may compel them to go back and check (e.g. that they have not run over anyone at the traffic lights). It is also quite common for people with OCD to believe that having a thought reveals some hidden aspect of their personality: ‘Although I see myself as a good person having this thought may mean that deep down I am not a good person’. Indeed, one way to identify how a thought is interpreted can be to ask the person: ‘What does having this thought say about you?’ People will often reply that they feel they are ‘bad’, ‘dangerous’ or ‘shameful’. Often people rationally know this belief not to be true. However, when they are very anxious, doubt starts to creep in and they can question whether they really are a good person.

Reminder: Our interpretation of thoughts keeps OCD going because we overvalue our thoughts. We see thoughts as a threat to ourselves or others and are compelled to act to ‘keep safe’. However, this just fuels the Vicious Cycle of OCD.

Responsibility for Action

Responsibility for Action means that the person believes they have the power to prevent something negative happening. They either feel they are the cause of bad events or feel they are capable of preventing them. However, there is a difference between being an ordinary, responsible and sensible person and having feelings of responsibility which lead to severe distress and disruptive rituals. When these feelings of responsibility become so disruptive it may be time to adjust your views on responsibility.

Reminder: Responsibility for Action keeps the OCD cycle going because the person thinks that they must do everything in their power to keep themselves or others safe.

Safety Behaviours

A Safety Behaviour is any behaviour that makes us feel ‘safe’ or lessens anxiety in the short term. Broadly speaking, Safety Behaviours can be divided into: Avoidance, Reassurance, Checking and Neutralizing Rituals.

Safety Behaviour	**Example**
Avoidance	Avoiding public toilets Avoiding films that may trigger violent thoughts
Reassurance	Giving responsibility to someone else – e.g. ‘can you assure me that nothing bad will happen?’ Getting others to check Carrying a talisman
Checking	Checking gas taps are off Checking the baby is still sleeping in the cot N.B. Often people check until it feels ‘right’: This can be a certain number of times; sometimes people have ‘good’ numbers
Neutralizing Rituals	Counting, reciting a prayer or mantra or maybe thinking ‘good’ thoughts Washing hands

Indeed, many people with OCD see Safety Behaviours as a logical solution to their fears. For example, Robert may think ‘what’s the worst that can happen if I wash?’ and ‘surely it is better to be safe than sorry’. However, Safety Behaviours actually fuel OCD.

Safety Behaviours keep us stuck in the OCD cycle as they:

- Focus our mind on the threat (e.g. washing or asking for reassurance keeps us thinking about possible dangers)
- Increase our level of doubt (e.g. did I really wash properly? Can I really remember whether I shut the door?)
- Increase our feelings of stress and exhaustion, which make it harder to dismiss intrusive thoughts
- Make intrusions worse (i.e. trying to block out thoughts just makes them more powerful)
- Prevent us from finding out that the worst does not happen.

This final point is illustrated in the following story:

A boy approaches a man who is waving his hands in the air in a rhythmical fashion:
Boy: 'Why are you waving your hands in the air?'
Man: 'To keep the tigers away'
Boy: 'But there are no tigers'
Man: 'See. It works!'

The story is humorous because the man thinks that his actions are keeping the tigers away. This is the same as Safety Behaviours in OCD: People believe that their checking, rituals and mantras prevent something awful from happening. If we look again at Figure 1. Robert thinks 'I am safe because I did my ritual'. In fact, Safety Behaviours only served to *prevent* him from realising that nothing bad would happen, even if he did not wash his hands.

Of course, there may also be times where we cannot ever be certain whether something bad has happened or will happen at a later date. For example, we can never guarantee that Robert will be 100% safe from future diseases, as this is a risk that we may all face. In these situations it is more difficult to demonstrate that safety behaviours have little bearing our level of risk, because the perceived danger is less testable. However, people can still learn how Safety Behaviours serve to focus their minds on threat, increase doubt and perpetuate anxiety. People can also learn to reconsider the level of responsibility for harm and practice sitting with doubt and uncertainty, as discussed below:

Role of Certainty

With OCD we often want to be *sure* we have done something (or not done something). However, how many things can we be actually 100% sure of? Not many, but sometimes we want to be as sure as possible. So, what processes do we use to help us with this? In general, we use our mind, our feelings and sometimes actions. We use our mind to look at facts and juggle alternatives; our memory to recall past events that may impact our decision and our emotions to confirm that we *feel* as sure as possible. We may also talk to others to ask what they think or do research about the issue we are trying to make a decision about. In general we leave this process to the big decisions in life; what job to do; what house to buy; who to marry etc. But if we start trying to use this process for the small decisions or about our general day to day tasks (e.g. leaving the house) we have a problem. This process is not designed for these decisions and when we try to be certain we just become overwhelmed and constantly uncertain.

Let's think about this.

Thoughts are just thoughts. Sometimes they are helpful and sometimes they are not but they are pretty unreliable and can be easily influenced by past experiences, others and just how we are feeling at the time. We also need to ask how reliable our memory is. Lawyers know that if they question someone long enough doubt starts to creep in. It is very hard to be sure we have reliably recalled something and the more we try to remember clearly the more unsure we become. Doubt takes over. OCD acts like that lawyer. It asks you to try and remember specific actions that did or did not happen. It is even harder if you are trying to remember something that *didn't* happen –i.e. that you didn't run someone over that morning. How can you remember something that didn't happen?

Also our emotions are not that reliable… negative emotions such as confusion, anxiety, feeling uncomfortable can often cloud the issue.

So trying to be certain is an impossible task. Most of our day to day and even big decisions involve an element of not being sure and taking a risk and seeing what happens.

One aspect of overcoming OCD is about learning to live with not being 100% certain about things, and that this is ok.

Reminder: With OCD we often want to be *sure* we have done something (or not done something). However, seeking certainty is problematic and often keeps OCD going.

Summary

1. OCD is maintained in several ways, including:
   - the way we interpret our thoughts (i.e. as dangerous)
   - the use of Safety Behaviours
   - the sense that we are responsible for negative outcomes
   - wanting to be certain

2. OCD keeps going as part of a vicious cycle and breaking out of this cycle is crucial to overcoming OCD

Chapter 3: How to Overcome OCD

Cognitive Behavioural Therapy with Exposure Response Prevention (CBT with ERP) is the most recommended treatment for OCD. CBT is a widely used approach that helps people challenge the thoughts that keep problems going. ERP refers to the technique where a person *exposes* themselves to a thought, object or situation which causes anxiety whilst choosing to *prevent* themselves from engaging in their usual safety behaviours. We discuss ERP and CBT techniques in more detail below:

1. Behavioural Experiments

Behavioural Experiments are planned activities that a person carries out to test a belief. They often form an important part of CBT treatment and can help us:

- Test catastrophic thoughts that keep OCD going
- Understand the role of Safety Behaviours
- Consider an alternative to how we usually think about things

Behavioural Experiments often involve testing things out in real life. This is important in order to gain insight at a cognitive *and* an emotional level. For example, people often report that they know they are not in danger, but this is not how they feel inside. Behavioural experiments help us to feel differently and believe in an alternative.

Let's think of an example:

Problem: Kath experiences obsessional thoughts about her family being harmed; any thought related to something bad happening to one of them has to be neutralized by rituals.
Target thoughts: If I think about something bad happening to my family it might happen (belief rating =70%). If I have not done anything to prevent it, then I will be responsible (belief rating =80%).
Alternative perspective: A thought is just a thought, it cannot make things happen.
Prediction: If I think a bad thought, it will happen. My anxiety will become unbearable and I will be unable to resist neutralizing.
Plan: See what happens as a result of gradually increasing 'bad' thoughts, first about the therapist, and then about her family.
Experience: Kath spent 10 minutes thinking about the therapist having a heart attack during her appointment. She then moved on to her family, starting with thoughts of a sprained ankle and ending with thoughts of the death of a loved one.
Observations: As she 'knew' her thoughts were illogical her conviction ratings were never higher than 80%, but her anxiety levels started off at 90%. Over time she gained confidence as each time her prediction failed to come true. Her belief that a thought could cause her family harm reduced from 70% to 40% and her sense of responsibility dropped to 60%.
Reflection: Over time Kath learned that thoughts are just thoughts and do not automatically make things happen. She was able to see that she could cope with the level of anxiety when testing this idea. She also recognised how anxiety focused her attention on threat and developed the following mantra for when she felt distressed: 'I am worrying about bad things happening at the moment because I am very anxious, rather than there being an increased risk'.

Adapted from Morrison & Westbrook, in Bennett Levy et al (2004)

Reminder: Behavioural Experiments can help us test catastrophic thoughts, understand the role of Safety Behaviours and consider an alternative to how we usually think about things.

They can also be used in a variety of ways (for more ideas please see Handout 2, p.40) and ready-made worksheets are available in Handout 3, p.42.

2. Setting Goals

When planning behavioural experiments it may be helpful to think of a future goal that you are working toward. Something broad such as, 'by the end of the year I don't want obsessive thoughts to impact my life' is difficult to define and may be too broad a goal.

It may be useful to consider setting **S.M.A.R.T** goals:

Specific: Check your goal says what you are specifically going to do
Measurable: Make sure you are able to tell if you goal has been achieved or not
Attainable: Is it possible for you to achieve your goal on your own, and ensure that it doesn't rely on the input of others?
Relevant: Is this goal important to you? Will it improve your quality of life once you've achieved it?
Timely: When will you have reached this goal? If it is a large goal it may be helpful to set yourself some smaller goals in between, in the lead up to this main long term goal.

Let's think of an example:
Eg.'I want to be able to use public toilets despite my fears of germs'

S- 'I want to be able to use public toilets when I'm out, wherever I am. Even if it causes me anxiety I will still use public toilets without using my safety behaviours. I will also not avoid drinking in public places so as to need the toilet less.'

M- 'I will know if my goal has been achieved if I am able to use public toilets when I am out without using my safety behaviours. I will not wait until I get home to go the toilet.'

A- 'This is an achievable goal that I can complete on my own without relying on others.'

R- 'This is really relevant to my everyday life. It will be better for my general well being and health if I am able to use public toilets.'

T- 'I will have completed this goal by Thursday 23rd January so I can feedback to the my therapist/ partner/ friend.'

3. Hierarchy

Often it is useful to break a goal into a hierarchy, starting with the most difficult task at the top.

Below is an example of how Angela put together a hierarchy: You may remember that she was worried about harming children and had to say a rhyme to make her feel safe.

Notice that the hierarchy consists of tasks focused on exposure AND response: It is no good doing a really difficult exposure task if you then 'neutralize' with hundreds of rituals!

Angela's Hierarchy:

1. Think thought of harming child (child present) **and** no ritualising (i.e. no countering thought with rhyme)
2. Think thought of harming child (child not present) **and** no ritualising
3. Think thought of harming child (child not present) **and** try to reduce number of times say rhyme by half (i.e. only 5 times)
4. Think thought of harming child (child not present) **and** ritualise as normal – i.e. say rhyme 10 times

Angela worked on the hierarchy with her therapist. First, she worked out the order of the items from the most difficult at the top, to the easiest at the bottom. She then worked on the exposure tasks - i.e. purposefully thinking of harming a child. She managed to start at point 3. and work her way to the top of the hierarchy. She discovered that nothing awful happened, even when she purposefully thought violent thoughts and resisted saying her rhyme.

You might find also find it helpful to create your own hierarchy. Usually we ask people to try tackling tasks at the midpoint of the hierarchy and then work their way up.

4. Theory A vs Theory B

Experiencing intrusive thoughts means that some people start thinking that they are a "bad" or dangerous person. Say, for example, that someone has intrusive thoughts about pushing someone in front of a bus. There are two theories here: Theory A is that they really are a bad person and that they want to cause harm to someone by pushing them in front of a bus. Theory B is that they are actually a very caring person and, because of this, they find the thoughts disturbing and anxiety provoking. People with OCD are very worried about causing harm. Remember, the very fact that someone is tormented by intrusive thoughts and has never acted on them before is an excellent predictor that they will not act upon these thoughts.

Robert worked on following table:

Evidence for Theory A: 'I am a bad person who is at risk of pushing someone under a bus'	**Evidence for Theory B: 'I am *very worried* I am a bad person that may push someone under a bus'**
- I have thoughts of pushing someone under a bus	-I have never acted on this thought before -I am a caring person who would not want harm to come to others -when I specifically stood at a bus stop with my therapist and thought of pushing her under a bus, my anxiety went sky high, but I did not act on this thought.

Robert found more evidence to support Theory B than Theory A and this helped him challenge the thought that he was a bad and dangerous person.

It may also be useful for you to construct a similar table and work towards finding evidence for each theory.

5. Reducing Reassurance seeking

Reassurance seeking can occur in many forms. We may ask someone whether we have locked the door or assure us that germs are not present. We may also look endlessly on the internet. However, reassurance seeking is unhelpful because it makes us:

- less confident in our own judgement
- less confident in sitting with uncertainty
- more likely to pass responsibility onto another person and avoid confronting our anxieties about being responsible for harm

Many people realise that reassurance seeking is unhelpful as it is impossible to guarantee that harm has not occurred or will not occur at a later date. However, people often feel compelled to seek reassurance because it offers some short term relief from anxiety. Asking another person to give this assurance is also problematic as we may start to doubt the truthfulness or sincerity of the person.

Reducing reassurance seeking is an important element of overcoming OCD and can be achieved by:

1. Noticing when you are seeking reassurance, and practicing resisting this urge
2. Sitting with uncertainty
3. Making a pact or contract with friends and family about what they should do if you seek reassurance

6. Getting Support from Family and Friends

Support from family and friends means they help you work on overcoming OCD. This is quite different from others participating in your OCD by carrying out rituals, avoiding certain activities or giving you reassurance.

You may want to share this booklet with friends and family. You may find it useful to explain what you have learnt so far. It may be useful to share the goals you have set, so friends and family can help support you with these. It is often important to have a conversation with others about what they should do if you ask for reassurance, and it can be useful to role-play this:

Person with OCD: ‘can you promise me that you saw me locking the door when we left the house’.
Family/ friend: ‘I can appreciate that you are anxious about this, but we agreed that I would not reassure you about this’

Tips for friends and family

1. Do not blame the person or yourself – OCD is a problem that often develops over time with no particular cause. It can be very disabling but is not a sign of ‘madness’. It is an anxiety problem that can be overcome with the right guidance and support.
2. Find out about OCD and talk about this with the person with OCD. Have a joint plan of how you will support the person to work on their fears and challenge their OCD behaviours.
3. Do not participate in OCD. Giving reassurance or partaking in the person’s rituals may feel like the kindest thing to do. However, this just serves to keep the problem going!
4. Be understanding and kind when a person asks for reassurance or asks you to partake in rituals but remind them this is not helpful.
5. Be prepared for setbacks. Overcoming OCD can be achieved through challenging habitual OCD thoughts and behaviours, but this will take time. Setbacks are inevitable and can be frustrating and demoralising. However, they can also serve as learning points of how to avoid such pitfalls in the future, and ultimately make us stronger.
6. Taking time out. OCD can be all-consuming and sometimes it is helpful to support the person in doing activities and hobbies that make life worth living. These can be small things to begin with like doing a crossword or going for a walk.
7. Communicate. OCD can be very distressing for all involved. Ask the person how they are feeling and whether they would like help with working toward goals. You may also find you need some support yourself, and in these situations it is important that you also find someone to confide in, be this a friend, partner or your GP.

7. Mindfulness

Mindfulness is an ancient Eastern practice which has been adopted within current mental health practices due to its benefits in reducing symptoms such as depression, anxiety and pain. It is a practical skill that enables a person to become more aware of their thoughts, feelings, and physical sensations in the present moment without judging or criticising themselves or their experience.

How can mindfulness help with OCD?
Mindfulness can help you to be more aware of thoughts, how these lead to compulsions and how you feel throughout the process.
It can help you:

- feel more in control of obsessions and compulsions (so compulsions may not stop, but there is an awareness to your actions so they are no longer an automatic and unconscious response)
- learn to relate to your thoughts differently…as just thoughts…not truths
- learn not to suppress thoughts
- realise there is no need to act on their behalf

People find that Mindfulness helps reduce self-criticism and judgement.

Let's think of an example:

Imagine you notice an anxious feeling, even if subtle. You also become aware of the thoughts that seem to accompany and strengthen the feeling.

If you can sit with the thoughts and feelings and accept them (accept their presence, not that they are 'truths'), observe but not get lost in them, or act on their behalf, they are more likely to pass.

You are now 'present' and not getting lost in time (future or past).

How easy is mindfulness to learn?

The skills of mindfulness are simple but, because it is so different to how our minds normally behave, it takes a lot of practice. We therefore need to be 'non judgemental' with ourselves as we learn this new skill.

A useful introduction to Mindfulness and how you can start using it in your day-to-day life is: Williams, M., & Penman, D. (2011). *Mindfulness: a practical guide to finding peace in a frantic world* (Vol. 360). London: Piatkus.

Summary

You can overcome OCD by:
1. Setting behavioural experiments which help challenge unhelpful behaviours and beliefs
2. Linking challenges into goals that are specific, and relevant to your life
3. Working through a Hierarchy
4. Building evidence for an alternative to OCD (i.e. Theory A/B)
5. Reducing reassurance seeking
6. Getting support of family and friends
7. Practicing Mindfulness

Relatives and friends can help by:
-encouraging the person with OCD to challenge themselves
-communicating with the person with OCD
-having confidence in the person and the process (i.e. anxiety is not harmful and does not send someone 'mad')

Relatives may want to avoid:
-punishing or criticising the person
-participating in OCD (e.g. reassuring the person or performing rituals on their behalf).

Chapter 4: Drug Treatment

NHS guidelines suggest that people should be offered intensive CBT (with ERP) or drug treatment where OCD is having a moderate impact on day-to-day living. Sometimes people may also be offered a combination of CBT and drugs.

The main drugs used in OCD are known as Selective Serotonin Re-uptake Inhibitors (SSRIs) and can include: Fluoxetine (Prozac), Sertraline (Lustral) and Paroxetine (Seroxat). Clomipramine (also known as Anafranil) is a different type of drug which may also be used. SSRIs are often called 'antidepressants'. However, they can also help to reduce symptoms of OCD and anxiety.

SSRIs are not addictive and can be used for a long time. However, research shows that if a person with OCD decides to stop SSRIs, symptoms can sometimes return. CBT with ERP (as discussed in this booklet) generally has better success in the long term, even after people have stopped treatment.

If you would like to start or stop medication at anytime it is important to discuss this with your medical doctor. Your doctor will also be able to advise you on the best way to take medication (for example, some people will need to take drugs for several weeks before they see any reduction in symptoms). Your doctor can also advise you on minor side effects that can occur.

Reminder - Lots of people find medication useful. However, if you are only offered medication but would like CBT, please tell your GP or doctor. Guidelines suggest that people with OCD should be offered CBT (with ERP) **or** drug treatment in the first instance and, in cases where there is only a mild impact on day-to-day life, brief CBT (without drugs) is recommended.

Summary

1. NHS guidelines suggest that a person with OCD that is experiencing a moderate impact on day-to-day living should be offered CBT (with ERP) *or* drug treatment
2. CBT with ERP (as discussed in this booklet) generally has better success in the long term compared to drugs, even after people have stopped treatment
3. If you are only offered medication but would like CBT, please tell your GP or doctor

Chapter 5: Potential difficulties

Struggling to self-motivate

It is sometimes difficult to reach the point where you are able to self-motivate yourself to get rid of OCD. The thought of challenging your compulsions may seem too anxiety provoking and much more difficult than just carrying out your rituals. Here, people find it helpful to work out the pros and cons of staying as they currently are, compared to making a change. It is then useful to compare each list: You will often find that the advantages of making a change will outweigh the benefits of staying as you are.

Angela worked on the following list:

Benefits to staying as I am	Benefits to change
• I will stay 'safe' • If I try I may fail	• I could develop my relationships • I would have more time to be myself • I could be more productive in work

You may also like to work on a similar table to set out some of the benefits of change. It may be useful to keep this on a small piece of card in your wallet or purse as a reminder of why you are challenging yourself.

Can you guarantee that nothing bad will happen?

People with OCD often want to be certain that something awful will not happen to themselves or others. However, this is an unrealistic goal and it is impossible to guarantee that nothing bad will ever happen in your life.

Although difficult, an important part of your recovery will mean sitting with a level of uncertainty. This may mean conducting a behavioural experiment where you purposefully practice going about your day-to-

day life without being 100% certain about whether any awful will happen, or not. It may mean noticing your urge to seek certainty and put these behaviours on hold.

It may also require you to face some of your fears in spite of the perceived risks. For example, Barbara is very worried about driving because of the fear that she will be involved in an accident. She has started to avoid driving because she cannot be certain whether they will be involved in an accident, or not.

What do you think will happen to the Barbara's anxiety and her perceptions of risk if she stops driving altogether? It is likely that she will become even more anxious and less certain about the dangers of driving. Therefore, although we can never be certain whether Barbara will be involved in an accident or not, helping her to face her fears and start driving again may actually mean she will be in a better place to assess risk more accurately. This is the same for OCD: In time people often find the less they focus their behaviours around being certain, the less they feel the need to be 100% certain.

Going beyond what is reasonable

Behavioural experiments can be used to test out the accuracy of our fears. In the early stages it can be useful to conduct experiments that create at least a moderate amount of anxiety. However in time, you may need to progress to tasks that seem unreasonable or may seem at odds with what people do in everyday life. For example, someone with fears of contamination may be asked to touch the toilet and then not wash their hands for a period of time. This may seem like an unusual request but the idea is that if we go beyond what is reasonable, we can then test out our very worst fears. It may also keep unhelpful behaviours to a 'reasonable' level in the long term.

What if I cannot identify my I fears?
Some people have lived with OCD for so long that they find it difficult to identify what it is that they are concerned about. They are unable to pin-point what they fear will happen and what they are trying to prevent: It has become an automatic response to carry out their ritual.

Here, it is often helpful to stop carrying out your usual rituals. You may then find that your intrusive thoughts come back to you. However, you may find that no matter how hard you try you can not identify your fears. In this case, a focus on reducing safety behaviours and making your life less dominated by OCD can still be very helpful. The focus of therapy would be on making your quality of life better, even though you are unsure of your exact fears.

Am I performing a Coping Behaviour or Safety Behaviour?

A useful way to identify a Safety Behaviour is to ask yourself whether anything awful would happen if you did not perform the specific action. For example, someone may think that unless they distract themselves, they may act on a violent thought. This is a Safety Behaviour. However, another person may use distraction to help do a difficult task like touching a ‘contaminated’ toilet seat. This may be a behaviour designed to help the person carry out the task. Here, the person is aware that distracting themselves does not have an influence on whether they will get a certain disease; instead they are using distraction simply to help them cope.

Can I catch OCD?
Some people worry that they may incorporate other people’s anxieties into their own OCD.

However, in our experience, people do not ‘catch’ OCD from others. Rather, by learning about the OCD cycle, it is possible to better identify OCD in oneself and others.

If I stop one OCD behaviour will another one just pop up?

Sometimes people will manage to get rid of one compulsion but replace it with another as they still feel compelled to manage intrusive thoughts and emotions.

However, by learning to identify safety behaviours and what maintains OCD (see Chapter 2) people can start to challenge their OCD. Ultimately, people discover that safety seeking behaviours have no helpful function; instead they just keep OCD going.

Worrying about physical symptoms

People with OCD sometimes worry about the physical symptoms that can accompany an increase in anxiety (e.g. an increased heart rate; a feeling of breathlessness). In some cases, people feel wary about challenging their OCD should their physical symptoms increase: They may even worry that they may faint or die. However, physical feelings of anxiety are totally normal and are not harmful. In many ways they can be challenged using an approach similar to OCD. That is, using Behavioural Experiments to set out predictions that can be tested (e.g. to test the fear that physical symptoms will cause fainting).

For more information on how to deal with Panic and anxiety, please see the ‘Coping with Panic’ by scrolling through the website: www.walkfree.net.

Another useful booklet is ‘Understanding Panic’ (Westbrook & Rouf, 1998) that can be purchased from www.octc.co.uk.

Maintaining your progress

Sometimes it is all too easy to slip back into old habits. Thinking ahead and planning how you will respond to OCD can be helpful. Clive worked on the following plan:

Times where I may be vulnerable to OCD	**What I will do**
Feeling tired may make me more likely to 'give in' to rituals and go back to checking the windows in my house	• Ask my wife to help me identify when I am feeling tired • Spend time relaxing (e.g. by watching comedy on tele)
Reading the newspaper and hearing about someone getting burgled	• Notice that OCD thoughts come and go (without having to act on them) • Remind myself of Behavioural Experiments where I challenged my fears

Using the above example, it may also be useful to think about the three main choices we can make when confronted with a lapse of OCD symptoms. These include:

1. The 'obsessional choice', which will make OCD worse in the long term (e.g. Clive may decide to act on the intrusive thought and check his windows)
2. The 'non-obsessional choice', which will help break the cycle of OCD (e.g. Clive may notice his thoughts but decide not to check his windows)
3. The 'anti-obsessional choice', which is difficult but helps people radically challenge their OCD and move toward a recovery more quickly. For example, Clive may notice he has an urge to check all the windows and perform 'Anti-OCD' by purposefully leaving a window open upstairs.

Remember: With any recovery from OCD there will always be ups and downs; recovery rarely follows a straight line.

Be kind to yourself when you notice any relapses and try to put in place the plan that you have set out. Indeed, the ability to efficiently cope with set-backs is a good indicator that your recovery will stay on track. Good luck!

Summary

1. Setting out the pros and cons of change can often help people realise why they want to tackle their OCD
2. It is impossible to guarantee that nothing bad will happen in life. Instead, learning to live with uncertainty is an important part of recovery from OCD
3. Sometimes recovery from OCD means pushing the limits of what people do in everyday life
4. Setbacks always occur, but can be managed in advance by making a plan of how you will respond to them

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Handout 1: **Intrusive Thoughts in the General Population**

This table shows the numbers of men and women (**without** OCD) who agreed that they sometimes had the following intrusive thoughts.

	% women	% men
Did I leave the stove or lights on that could cause a fire?	79	62
Left the door unlocked and an intruder could be inside	77	65
While driving, an impulse to run the car off the road	64	53
I could get a sexually transmitted disease from touching a toilet seat or handle	60	40
Even though the house is tidy, an impulse to check that absolutely everything is put away	52	40
Feel sudden impulse to say something rude or insulting to a stranger	59	55
Impulse to say something rude or insulting to a stranger	50	55
While driving, the impulse to swerve the car into oncoming traffic	50	49
The thought of having sex in a public place	55	67
The thought of having sex with an authority figure (e.g. minister, boss, teacher)	51	62
While driving, the thought of running over pedestrians or animals	46	53
When talking to people, intrusive thought of their being naked	44	63
Impulse to indecently expose myself by lifting up my skirt or slipping down my trousers	14	24
Impulse to masturbate in public	11	16
When I see a sharp knife, the thought of slitting my wrist or throat	20	22
When in a public place, the thought of becoming dirty or contaminated from touching a doorknob	35	23

From Purdon & Clark (1993) and Byers et al. (1998)

Handout 2: Types of Behavioural Experiments

Aim	Possible Behavioural Experiment
To discover importance of Catastrophic Interpretations	Angela does a survey of her friends. Beforehand, she has a belief rating (=80%) that they never experience any intrusive violent thoughts. However, after speaking to her friends she realises that many have occasional violent thoughts (e.g. driving the car off the road) but rarely pay much attention to them. Outcome: -Angela's belief rating that no one else has intrusive thoughts falls to 20% -Angela starts to question whether she ascribes too much importance to thoughts. She starts to think: 'maybe a thought is just a thought…it does not make me a bad person or a risk to others'.
To discover the importance of factors that maintain OCD	Robert works with his therapist to set an experiment in which he purposefully washes his hands even more than usual on one day (and then less than usual on another). He predicts that he will feel less anxious when he washes hands more often (belief rating = 75%) Outcome -Robert realises that washing his hands more actually focuses his mind on his intrusive thought of contracting AIDS. He also discovers that washing his hands less is difficult at first but then allows him to get on with gardening and takes his mind off his intrusive thoughts. His belief rating that washing would make him less anxious reduces to 20% -Robert is able to use the experiment to understand the role of Safety Behaviours in maintaining anxiety

Continues overleaf

Handout 2 (cont)**: Types of Behavioural Experiments**

To generate evidence for an alternative explanation	Clive believes that he is at great risk of getting burgled (belief rating = 95%) and recalls reading a newspaper article that reported rates of burglary in his area being very high. Clive agreed to re-read the newspaper article and circle those statements that suggest his area is prone to burglary, or not. Clive realised that he had only paid attention certain parts of the newspaper article. On re-reading it he found that the numbers of burglaries were once higher than average, but these nearly always involved shops and that with recent police initiative these had now reduced. Clive belief that he is at risk of getting burgled reduced a small amount (belief rating = 85%). However, Clive was also able to realise that he often focuses on threatening information (e.g. getting burgled) at the expense of any alternative information. He began to appreciate that his anxiety may sometime be due to what he focuses his attention on, rather than seeing the 'bigger picture' and appreciating risks may actually be quite low.

Handout 3: Planning your Behavioural Experiment

1	What is the behaviour I am going to challenge? *E.g. I would like to challenge the behaviour of cleaning the shower cubicle before every shower.*
2	Is there a fear / belief that I am testing out? How much do I believe this (0-100%)? *E.g. Without cleaning the shower, I believe I will get infected and get a fever (Belief rating= 65%).*
3	Describe in detail what you are going to do? *When I shower [on date dd/mm/yy] I won't spray any part of the cubicle with anti-bac spray or shower spray. I will get straight in the shower and wash.*
4	What happened? Did your belief rating change? *Although it was uncomfortable I managed not to use anti-bac spray. My belief about getting infected reduced to 45%.*
5	Any particular problems? Did you drop all Safety Behaviours? Are there any other ways you can test your belief? *The next day I used Safety Behaviours (i.e. anti-bac spray) as usual . This may have prevented me from testing my fears long term.* *As a result, I intend to practice not using anti-bac spray all next week (dd/mm/yy to dd/mm/yy).*

Updated WH 13.4.16