MANAGING OBSESSIVE-COMPULSIVE DISORDER

Dr. Simon Enright. Department of Clinical Psychology
Berkshire Healthcare NHS Trust.
Supported by Berkshire Health Promotion Resources
01753 638678 www.bhps.org.uk/resources

HOW TO USE THIS BOOKLET

The aim of this booklet is to take you on a journey of rediscovery. It will attempt to boil down all the theory and strategy that you've learnt in therapy or read in books, into some simple but crucial facts about the nature and management of OCD. The most important of these is this:

Your problem does not lie in the fact that you have disturbing intrusive thoughts. Rather, it's how you have learnt to deal with these unwanted thoughts and images that causes your intense distress and prevents the problems from going away.

The task of this booklet is twofold:

1. To convince you that it is the way that you choose to respond to your intrusive thoughts that will determine whether or not you can gain control over them.
2. To offer you alternative ways of responding that will ultimately lead to a significant improvement.

The journey starts with helping you to understand more about how certain styles of thinking can cause you such distress and seem to become really stuck or endlessly repetitive. The booklet will examine alternative ways of thinking about and dealing with these intrusive thoughts, and how your choice to adopt a different strategy will make all the difference.

The path will navigate through cognitive and behavioural therapy (CBT). These ideas have greatly enhanced our understanding and strategies towards helping people to manage the causes and symptoms of OCD.

You will notice that nowhere in the booklet is there any mention of finding a total cure. The aim of the booklet is to help you to increase control over your problems, eventually to a point where they are no longer troublesome. Overcoming OCD requires patience, devotion, courage and determination, but first it requires a clear understanding of what to do and just as importantly, what not to do. Read this booklet slowly and frequently. Try to apply what you read to your own problems and make these methods work for you.

INTRODUCTION TO OBSESSIONS & COMPULSIONS

Some Definitions and Facts.

Obsessions are repetitive, persistent ideas, thoughts, images or impulses that come into our minds and which are experienced as senseless or unpleasant. The person recognises that these are his own thoughts but that they are unwanted and so he will attempt to resist or get rid of them.

Common examples include:

- Recurrent thoughts of contamination by dirt, germs or HIV/AIDS.
- Recurrent thoughts or images that a member of the family or a friend might become seriously ill, injured or die.
- Recurrent doubts about having caused an accident.
- Thoughts or images of committing acts of violence, sexual abuse or causing other people harm.
- Recurrent obscene thoughts or blasphemous ideas, often linked to the idea that one might blurt these out or unknowingly write them down.
- Recurrent worries about your own health or someone close, imagining that your thoughts can in some way influence their well-being.

Compulsions are often directly linked to obsessions and are repeated patterns of behaviour or thought that are carried out because of a very strong urge or feeling of pressure to do so. The behaviour often occurs in an attempt to prevent or produce some event or situation. We are deceived into believing that our compulsive behaviours can influence or resolve the things we worry about and thereby make us feel better. However, the activity is often not really connected to the desired outcome, certainly it has no real influence and is repeated senselessly. There is rarely any pleasure from carrying out the activity but it can bring temporary relief from feelings of tension, anxiety or frustration.

Common examples include:

- Repeatedly washing hands, often in a very specific way, until they are very sore and even bleeding.
- Constantly checking doors, gas appliances, taps, electrical goods and plugs. Often this checking is done in a set sequence which must not be disturbed otherwise the checking must start again from the beginning.
- Going back over the route you have just driven to check that you haven't caused any accidents.
- Unsealing letters you've written to check and recheck the contents.
- Touching light switches or the corners of a room or specific objects in a set manner.
- Constant washing or disinfecting work surfaces, crockery or utensils.
- Always neatening or straightening items to put them in their exact place.
- Repeated use of the toilet before certain events in order to be 'safe' or to be able to enjoy them.
- Repeated washing of clothes even when they're perfectly clean.
- Constantly seeking reassurance from friends and family that what you have done was OK or safe.

Compulsions can also be 'covert' or hidden mental activities which no-one but the sufferer knows are going on. Examples of covert compulsions include:

- When reading, the need to end with a 'good' word, letter, or page number. Also, the need to miss out a certain line, re-read bits or avoid certain 'bad' words.
- Saying silently a specific set of words, or conjuring up a specific image whenever one hears about or predicts a problem or disaster.
- Swapping 'unacceptable' words or images that come to mind for 'safe' ones.
- Spending vast amounts of time and effort trying to remember specific details of a conversation, event or TV programme.
- The need to think a specific thought or think of a specific image on seeing an object of a certain colour.
- Endless counting rituals, numbers or letters, associated with certain activities.

How Common is OCD?

Recent surveys suggest that OCD is in fact among the most common of mental health problems. The National Institute of Mental Health in the USA recorded a lifetime prevalence rate of OCD in the general population of between 1% and 3%. Very similar results have also been reported in Britain, Canada and India. So up to 1 in every 30 people has obsessive-compulsive disorder.

Until recently, many of these people did not come forward for treatment. They may have felt ashamed or embarrassed about their problems, or they had no idea that help was available. However, many people have watched recent television documentaries on the subject of OCD or discovered in the past few years the many self-help books (some of which are listed in the back of this booklet) that have appeared which deal specifically with understanding and overcoming OCD.

OCD affects men and women in equal numbers. Approximately 75% of all cases of OCD have been diagnosed by the age of 30. In roughly half of cases the problems began and developed gradually. There may be times when the problem is much worse and others when it is relatively under control. The worsening of symptoms is often related to other life stresses or periods of low mood.

Re-defining the OCD Problem

The fact is that everyone has intrusive thoughts. Studies have shown in fact that there is no difference between OCD suffers and other people in the types of random thoughts they have, nor is there any difference initially in the frequency with which these random intrusions occur. However, there is a fundamental difference in the way that OCD sufferers respond to their thinking and misinterpret their intrusions. It is exactly this pattern of misunderstanding that inevitably leads to the thoughts becoming stuck and very disturbing.

A good example of this is the person playing with their children who has

the brief spontaneous thought: 'I could harm that child!' Thoughts similar to this one are common to most parents (and non-parents) at some time or another. They obviously don't mean it. It's just a fleeting intrusive thought. However, a person with OCD may believe that the fact that the thought occurred at all, means that there is a risk, however small, that they could act on the thought and harm the child. Or they might think that having the thought must indicate some unconscious desire to harm children. As a result of these entirely erroneous beliefs, based on entirely bogus logic, the person becomes preoccupied by the thought and acts to avoid the fictitious risk by one or more of a variety of means e.g.:

- By not being left alone with children.
- By seeking constant reassurance from friends and family.
- By performing some ritual behaviour "to make them more safe."
- By repeating a specific word or sentence creating a "safe image".

Each of these strategies is an attempt to try to 'neutralise' or 'undo' the threat or harm falsely assumed from the original thought.

How Does OCD Start and What Keeps it Going?

Obsessional beliefs are always related to important issues for us, things that we personally care about:- harming others, illness and death, religion, being capable, behaving well, being liked and so on. When we get intrusive thoughts or images that directly challenge our most important values we may find them hard to ignore. However, it is precisely the way we then chose to cope with this dilemma that can lead to the development and maintenance of the OCD. The following section attempts to spell out some of the mistakes that we become caught up in.

Underlying Beliefs

Most people who are prone to develop obsessional problems tend to have **exaggerated beliefs about personal responsibility**. They interpret their thoughts in a manner that makes them feel intensely, personally responsible for causing or preventing harm. They feel that not trying to prevent harm is the same as having caused the harm. They believe that if the predicted disaster actually occurred it will be their fault or that they will be

blamed. Linked to this are other people with OCD who exhibit a **magical belief** that their thoughts can somehow influence real events in catastrophic ways. They then terrify themselves that the more they think about something the greater is the risk that it may happen.

Another pattern of belief associated with OCD lies in the **need for certainty or control**. People convince themselves that not knowing an answer to a problem or specific fact, or not having total control over themselves, situations or their thoughts, will lead directly to some disaster whether specified or not. This type of thinking can also underpin the need for order and symmetry of routines or possessions. Other OCD sufferers report believing that **thinking a thought is almost as bad as acting it out**, or they may believe that **having the thought means that they secretly or unconsciously want to do it**.

In each of these thinking styles there is a common theme. The person feels that they cannot take the risk of ignoring their thoughts because, according to their misinterpretation, the imagined catastrophic outcome for which they will be responsible or blamed is too awful to bear – the stakes are always too high! No matter how many times the disaster doesn't happen, the person can always convince themselves *"This time is different!"* Despite endless false alarms the person rationalises that it is only their own vigilance and the power of their neutralising compulsions that have kept them and others safe, not the fact that the situation was inherently safe.

Compulsive Rituals

A very common idea held by people with OCD is that if they could just perform their rituals perfectly then everything would be fine. This is entirely wrong. Striving to repeat the ritual will inevitably prolong and intensify the OCD. However, just as important, undertaking compulsive rituals will prevent the person from realising that the situation was inherently safe requiring no action at all, and that the anxiety they feel will diminish naturally if the thought, image or situation is not avoided.

Avoidance

Overcoming any fear is about facing it head on. We may wish to do this gradually at first but ultimately, to gain control over the fear we must confront our demons. Every time we avoid facing the fear by carrying out a neutralising ritual, it strengthens this association and undermines our confidence a little more. Even more important in OCD is that avoiding facing a situation we fear prevents us from finding out that nothing bad would have occurred anyway.

There is a humorous story that psychologists often tell about a woman who was walking along a road when she came across a man waving his arms about in the air. *"Why are you doing that?"* asked the woman. *"To keep away the dragons"* said the man. *"But there aren't any dragons"* replied the woman. To which the man responded *"That just shows how effective this is"*.

Reassurance Seeking

This is another way of avoiding the problem. Seeking out someone else to take responsibility for your actions or lack of them is not addressing the fundamental issue of you deciding to act to really face your fears head on and to challenge them. Another problem with seeking reassurance is that other people's sympathy and willingness to discuss the problems can inadvertently validate them and appear to justify the worry.

Trying to Suppress Unwanted Thoughts.

There is one style of thinking that consistently differentiates people who suffer from OCD from those that exhibit other anxiety disorders. This is the belief that *"it is possible and necessary to control one's thoughts"*.

A natural strategy when one gets a very unpleasant thought might be to try to not think about it or deliberately suppress it. However, this may in fact make matters worse. The 'White Bears Experiment' has dramatically changed the way we understand people's attempts to suppress or neutralise

their unwanted thoughts. The following dialogue describes the experiment and what we can learn from it:-

***Therapist**: I want to try an experiment to test out your idea that you must have control over your thoughts. Over the next two minutes I want you to think about anything you like except a white bear. It's very important that you don't think about a white bear at all and that you try to take your mind away from thoughts of a white bear altogether.*

(**Person** tries for two minutes, eyes closed, in silence not to think about a white bear)

T: *OK, stop! Now what was going through your mind in the last two minutes?*

P: *Thoughts and images of white bears. Hundreds of them!*

T: *What happened to the image of the white bear when you tried not to think about it?*

P: *It kept coming back into my mind. I tried really hard but it was very hard to get rid of it.*

T: *OK. Let's try a different experiment. What I'd like you to concentrate on is holding your mind on the image of a white bear. Try and keep it there as long as you can. Try really hard.*

(Person tries to focus attention for two minutes in silence)

T: *How easy was it to keep the image of the white bear in your mind?*

P: *Not that easy. It kept fading.*

T: *OK, let's summarise the two experiments. In the first experiment the more you tried not to think about white bears the more they came into your mind. That seems to have some similarities with how you try to cope with your obsessional thoughts. You try to push them out of your mind and they keep coming back. In the second experiment, while you were deliberately trying to think about white bears, the images kept fading.*
So what would happen if, instead of trying to push your obsessional thoughts and images out of your mind, you tried to hold them there?

P: *I guess they might fade. But I find it upsetting to have those images so I'd feel worse.*

T: *In what way would you feel worse?*

P: *Well if I focus on the image, my anxiety will increase and it will just become totally out of control.*

T: *There is another possibility. We've agreed that trying to push an image out of your mind keeps it coming back. If we think about the image which causes you anxiety, then isn't it reasonable to assume that just as the image fades when you deliberately focus attention on the image of a white bear for two minutes, so the anxiety will fade too? How about if we conduct an experiment now, by recalling this image and trying to hold on to it in your mind and see what happens?*

The importance of the White Bears experiment is that it offers us an answer to why certain images and thoughts seem to get so stuck and therefore it also gives practical advice in how to manage OCD. These were only images of white bears. Imagine how much harder we might want to get rid of thoughts and images that really bother us!

Unwanted thoughts and images happen to everyone. The reason that some get stuck seems to be directly related to how we react to them. Becoming upset or angry with the thought, feeling embarrassed or ashamed, or

feeling very responsible for doing something following the thought, - each of these reactions will intensify the thought and increase its likelihood of coming back. The more we then try not to think something the more the image or thought will plague us.

Do not be afraid or ashamed of the images and thoughts that come into your mind. **They're just thoughts! Thoughts will not harm you or anyone else. There is not a single example in the entire history of humanity when a person's thoughts alone have brought about disaster. Disasters come from doing not thinking!**

So, if you find a particular image or thought distressing then instead of trying to get rid of it (like trying not to think about the white bear!), accept it, stay with it, have no fear of it and just like the experiment tells us, it will fade away.

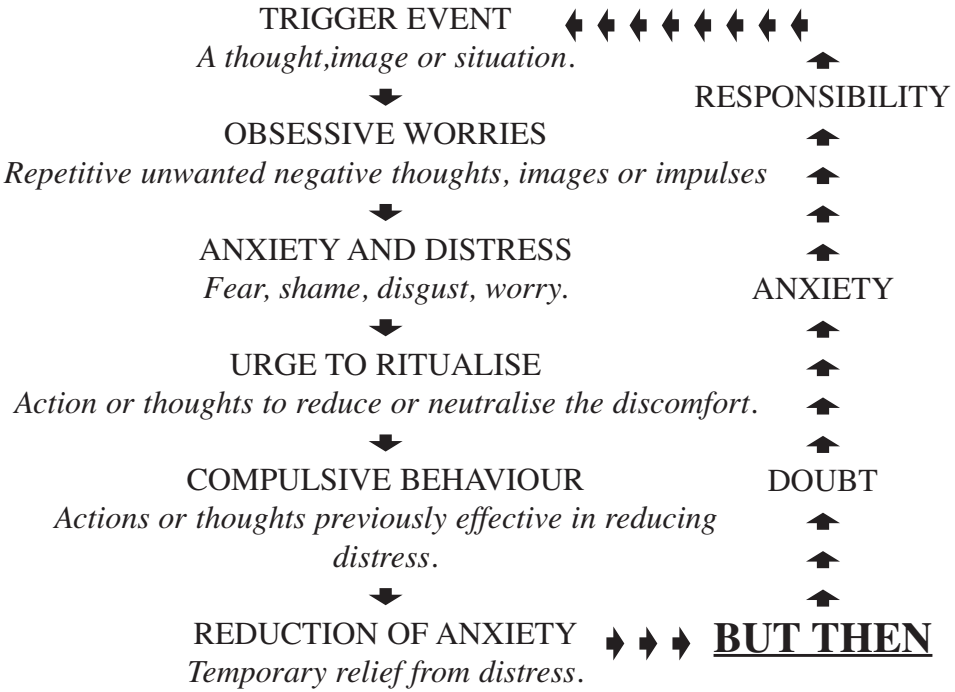
It's worth noting that there was a second important phase to this experiment in which subjects were told not to think about a white bear but that if they did, they were immediately required to switch their attention to an image of a red car in their mind and focus on this. The researchers found that this simple method of distraction greatly reduced the frequency of white bear images.

Linking Compulsions with Obsessional Thoughts

Any behaviour which helps a person reduce anxiety or distress will become quickly established. Since obsessional thoughts and images cause the sufferer discomfort, the person will naturally be looking for ways of reducing this discomfort as quickly as possible. When you find a method that works for you the chances are you'll stick with it.

For example, if I believe that I am very dirty, I will feel uncomfortable until I am able to wash. The act of washing reduces my discomfort and becomes an automatic strategy for reducing my anxiety again in similar

circumstances. This may begin to explain the development and worsening of OCD symptoms along the lines of the following sequence of events:



The person with the obsessional problem acts to reduce their anxiety in any manner that seems to have worked before, even if this action has no logical impact upon the feared outcome.

Let's look at an example of this model in action:

> *John had a fear that he might leave an electrical appliance switched on which might cause a fire. His trigger events were leaving the house or going up to bed. At these times he would automatically have obsessive worries such as: "Is the house safe? Could anything cause a fire?". This would then lead to anxiety and distress with feelings of tension and panic together with further worrying thoughts such as: "Did I really turn off the T.V., kettle, washing machine, kitchen light*

etc.?", "What if the house burns down?". John would become so overwhelmed by these worries that he would feel compelled by the urge to ritualise to reassure himself that everything was all right. This then led to his compulsive behaviour of going round checking everything electrical in the house, turning on and off switches, checking all plugs, checking the cooker and so on. After half an hour or so, he would have reduced his anxiety to a point where he could go back to bed or leave the house. Unfortunately however, the doubts would then often come back after a few minutes and the cycle would start again.

What is clear from this example is that John's method of coping with his obsessional thoughts may reduce his anxiety in the short term. However, giving in to this urge to ritualise simply sets up an endless cycle in which the problem keeps coming back. Worse still is the fact that in performing any compulsive patterns of behaviour, these can then become associated with a range of environmental features or 'triggers'. Initially, these will be closely associated with the behaviour but with time the triggers will grow in number and variety. These then provide a diverse range of reminders, most of which we are unaware of, to trigger the obsessive thoughts automatically.

TO SUM UP SO FAR…..

Normal intrusive thoughts are misinterpreted by OCD sufferers as signals of danger to self or others. This misinterpretation leads to intense anxiety which the sufferer seeks to escape by trying to avoid the unwanted thought or neutralise it with compulsive rituals. Trying not to have certain thoughts is impossible. Trying to neutralise them sets up a powerful association between the intrusive thoughts and compulsive behaviours that leads to a marked increase in both.

Other Factors That May Help Explain OCD

Complementary to what you have already read, there are a number of different ideas which may all have some contribution to make in understanding the problems of OCD:

Family Influences

Approximately 5% of OCD sufferers have a close relative with the condition. This is only a little higher than the general risk of 2 or 3%. Identical twins have a higher common incidence of OCD than fraternal twins, so it is possible that there may be a weak genetic link. There is also some evidence that over-strict parenting may be associated with OCD in later life though again, this is far from inevitable.

Biochemical Factors

These theories assume that there is some chemical imbalance or other irregularity in the brain of OCD sufferers that is associated with the disorder. Research in this area is relatively new and still has a long way to go before anything definite can be concluded. However, there is a more consistent body of evidence which has identified a particular brain chemical, called Serotonin, which may be related to OCD problems.

In OCD there is evidence that there may be an abnormality in the transmission of information via some serotonin neuronal pathways. The precise nature of this problem is unclear, but some patients with OCD respond to medication that increases the Serotonin available within the brain. These chemicals are called SSRIs- Selective Serotonin Re-uptake Inhibitors. Currently in 2006 in the UK, the SSRI drugs licensed for treating OCD include Fluvoxamine (Faverin), Paroxetine (Seroxat) Sertraline (Lustral), Citalopram (Cipramil) and Fluoxetine (Prozac). Clomipramine (Anafranil) is also used, though this is not an SSRI. The use of medication in treating OCD will be discussed later in this booklet.

Mood

Many people with obsessional problems can identify a relationship between their mood and their obsessions. Feeling stressed, low or tired can

often be associated with a worsening of symptoms. Women often find their OCD problems are worse just before menstruation and they may report an increased difficulty at this time resisting compulsive behaviour.

Some research proposes that there is a direct association between swings in mood and the development of obsessions. This theory suggests that whenever our mood changes dramatically we become more susceptible to developing obsessional problems. A good example of this is the behaviour of some students at examination time. The usual response to exams is a change in mood towards becoming more anxious. At such times we can develop unusual behaviours; perhaps becoming more particular about our routines or the things that we eat or we may want to have a lucky charm with us in the exam, etc. Though these behaviours in most of us do not amount to clinical problems, they do suggest that mood may have a part to play in developing and maintaining OCD.

There is evidence to suggest that at specific times when our mood has changed suddenly and dramatically, we may be particularly vulnerable to a process called 'Over-learning'. It is usually the case that whenever our mood is altered significantly by unexpected news or the occurrence of a sudden event, for instance hearing about a death, or a disaster, or having a car accident, or even a very happy event, we can often remember exactly what we were doing in that moment.

Psychologists believe that it is the sudden change in our mood which is responsible for the development of these intense memory associations. At such times it seems that we capture every detail of this moment forever. This is why people who are old enough can usually tell you exactly what they were doing when Neil Armstrong became the first man to land on the moon, or when they heard news of Princess Diana's death, or when the 9/11 atrocity occurred.

Some people believe that clinical obsessions may be similar to these deeply held memories that seem to be very strong and long lasting. This is why a number of the methods suggested to help reduce obsessional symptoms are aimed at helping people to manage their mood.

Recording Your Obsessive – Compulsive Patterns

A useful way of trying to identify more clearly the exact obsessional problems you may have, is to keep a careful record of these. The following chart is one way in which you might do this.

Day /Time	Obsessional Thought and/or Compulsive Behaviour	Highest Level of Anxiety (1 - 10)
Monday 12th 12 noon	Feared dirty bus seats. Washed hands 10 times after coming in from shopping.	8
1.30pm	Is the house secure? Checked back door was locked 3 times before going out.	7
Tuesday 13th 9.00 am	Had repeated violent thoughts of harming the family. Counted to 200 in my mind.	10
Wednesday 14th 10.00am	I must keep this it may be needed. Added yesterday's newspaper to collection.	1
12.05am	Sealed envelope at work. Terrified I might have sworn in an official letter. Opened it, checked and resealed – 3 times.	9

For people who have very recurrent obsessional problems, it might be very difficult to write everything down. However, the more detailed the records, the clearer becomes the picture of exactly what the problems are. It is also important to note how anxious or upset the problem made you feel. Though this can change at different times, it may be possible to begin to identify which are the more severe problems.

Cognitive-Behavioural Therapy CBT

CBT for OCD is based on the fact that everyone gets unwanted intrusive thoughts and images but that only those people who worry about them in a way that makes them highly significant, will go on to develop OCD.

What then makes the unwanted thoughts so frequent and become so stuck is the desperate attempts that people make to try not to have them or to neutralise them.

Theory A & Theory B

Most people with OCD are convinced that their worries represent REAL danger and that their compulsive actions are absolutely necessary to prevent this danger from occurring. Let's call this idea Theory A.

The alternative to this, Theory B, might suggest that the obsessional thoughts and images represent an IMAGINARY danger brought about because people with OCD tend to be very worried about being responsible for harm and danger in the presence of their unwanted thoughts.

If Theory A is correct then it is critical that people do everything they possibly can to protect themselves and others and to avert the danger. However, if Theory B is correct then acting in this way would be entirely unnecessary and simply serve to maintain and heighten the worry and waste inordinate amounts of energy and time.

Of course it's not usually as clear cut as this. Most people who suffer with OCD will tell you that they are not absolutely convinced that Theory A is totally correct but they assume that even if it is only slightly, possibly correct, it still indicates a need to act.

CBT helps OCD suffers to take the risk to reject Theory A altogether and ultimately to believe totally in Theory B. Initially, this will seem a very, very tough demand. You may have spent a significant portion of your life acting with assumed sole responsibility to ward off danger or behaving in a way so as to prevent a possible disaster. If so, then someone telling you to stop doing this because it has always been unnecessary, presents you with a huge challenge and a very difficult choice. And so, CBT insists that you do not just believe this booklet or your therapist, but rather, you work using the therapy to PROVE TO YOURSELF that Theory B is correct.

Testing and Proving Theory A or B

One of the key components of CBT involves setting up specific situations or experiments to test out whether Theory A or Theory B is correct. These real-life experiments allow us to look at the evidence they offer us and reconsider whether Theory A or B is most likely.

For example, people with compulsive checking routines often feel that they must check and re-check something to avoid a disaster. Let's say someone feels the need to re-check a tap is off, fearing that a flood may occur, or you lock the front door without re-checking it when leaving the house. Theory A suggests that a flood or burglary may occur if the checks are not carried out. Theory B suggests there is no real danger, just anxious and catastrophic thoughts, so not checking the tap or front door will possibly make the person more anxious for a while but no disaster will occur. So to test the validity of A or B the person may decide not to check at all and see what really happens. Obviously the more this experiment is repeated, the more evidence we will amass and the more fully we can endorse Theory A or B. Does any disaster occur (A) or do you just feel anxious for a while and this anxiety gradually fades away (B)?

Alternatively, another person may worry that they must neutralise an intrusive thought about harming a child. Theory A suggests there is a real danger to children here and Theory B suggests only anxiety. An experiment to test A or B may be to continue to play with the children and stay with the intrusive thoughts without attempts to neutralise them.

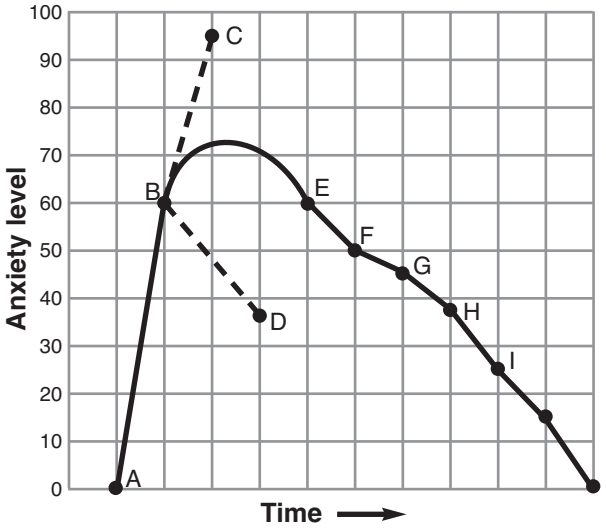
Another example might involve not washing your hands when you feel they are contaminated, or deliberately touching something you feel is unclean and not washing your hands. Does any disaster occur or do you just feel anxious for a while and this anxiety gradually fades away?

When undertaking these experiments it is very important to be absolutely clear that ***the anxiety you experience cannot harm you***. We will return to this fact a number of times in the booklet. Undertaking such experiments may seem like a huge risk at first but they are essential to proving to ourselves that our catastrophic fears do not happen. Yes, people are flooded, burgled, children assaulted, and people poisoned – but **NEVER** because someone, somewhere had an intrusive obsessional thought!

This process of testing Theory A or B is also known as 'Exposure and Response Prevention'. Current research suggests that this is the most effective treatment for treating all forms of OCD - to encourage the person to face up to their fears (called '**exposure**') without performing compulsive routines or neutralising (called '**response prevention**'). When you think about it, you have probably already achieved this task on a number of occasions in the past.

Let's take the example of a man who has just got off the bus and who is convinced that he has been contaminated by touching the seat he'd been sitting on, i.e. He has been exposed to his worst fear. He arrives home with the sole intention of immediately going to wash his hands and change his clothes to try to reduce his feelings of anxiety. As soon as he gets in however, the phone rings, his compulsive response is prevented. It's his friend ringing to see if he wants to go out to the pub tonight, and asking if he'd seen the football on T.V. last night. Though reluctant to talk at first, the man becomes distracted and gets into a conversation about the game. By the time he's put the phone down, the urge to wash and change has reduced so much that he no longer feels it necessary.

The important lesson to learn from this is that anxiety will always decrease given enough time. This is shown in the following graph:



Let's relate the curve shown on the graph to a specific obsessional problem. The first part of the graph from A to B shows the person's anxiety going up very fast in a short space of time. This might represent the sudden increase in anxiety that a person with checking compulsions may feel when he wakes in the middle of the night and thinks; '*Did I lock the back door?'*. This rapid emotional reaction to the thought has become automatic for the checker, since he fears danger or threat from the tiny possibility that, despite all of his previous checking that night, the back door may still not be properly locked and that this may lead to disaster.

At this point the person has two choices. First, to try to forget the door and go back to sleep, in which case the course of his anxiety would follow the solid line of the curve from B to E and to I and beyond, staying high for a while but then gradually going down naturally. Or second, the person might choose to give in to his anxiety, assuming that it will go on increasing to intolerable levels at C until he checks the back door again. In this case the act of getting out of bed and checking the door will reduce his anxiety in the short term, as shown in the dotted line from B to D, but after a while the doubts will inevitably creep back and the whole process will repeat again.

It has been demonstrated time and time again that **the only way to overcome the feelings of anxiety associated with OCD problems is not to give in to them.** Resisting the urge to perform compulsive behaviours or thoughts and to put up with unpleasant anxiety feelings in the short term, means that in the longer term you will reduce your anxiety and beat your obsessions. This is a battle - the enemy is the obsession.

The Task of Facing the Fear

Facing up to a fear is the only way to conquer it. In overcoming OCD there are two main ways of facing our fears; direct and imaginal. The first relates to actually confronting the fear in reality. That might include the task of sealing a letter and posting it without checking, touching the bottom of a pair of shoes, or visiting a unit where the patients have AIDS. However, when it is not possible to face the fear in reality because either the fear itself is an imagined event or the fear relates to something that we

are unlikely to have access to, then exposure can also be achieved by using the imagination. These two methods are now discussed in detail.

Direct Exposure - Getting Started

The first task of the technique of exposure requires the identification of as many situations as possible which lead to obsessional worries that in turn lead to the checking, cleaning, or other rituals. Make a list of all of these. The following is an example of a list that someone with an obsessional fear of contamination leading to compulsive hand washing might make:

Item leading to urge to wash	Urge to wash 0-100	Anxiety if not washed 0-100
Door handles at home	80	85
Door handles in public	90	95
Dried blood /red spots	100	100
Milk bottles	35	35
Dustbins	80	75
Dirty laundry	35	30
Public toilets	100	100
Bus seats	75	70

A person with obsessional thoughts about having forgotten something or not having done something correctly might develop compulsive checking routines and their list might include the following:

Item to be checked	Urge to check	Anxiety if not checked
Gas cooker	90	95
Video player	50	45
Television	65	70
Back door	100	100
Front door	95	95
Kitchen window	80	85
Lounge window	35	30
Gas boiler	100	100
Microwave	75	70

The process is applicable to all obsessional fears that have led to compulsive patterns of behaviour. Once the list of things leading to compulsive behaviours has been established, the next task is to put these items into an order based on which causes the most and least anxiety. The least anxiety provoking item then becomes the first target for the process of exposure and response prevention - testing Theories A and B.

The chosen first target is repeated several times each day if possible, until the anxiety associated with the task lies below 20/100. It is difficult to say how long this might take but we know that repeated exposure and response prevention with any task will reduce anxiety. It will also amass evidence, hopefully leading to an increasing conviction in the truth of Theory B.

It is essential that the exposure task is carried out in full. If the task requires touching a specific 'contaminated object' it is important to do so fully with both hands, prolonging the event for as long as it takes to begin to feel less anxious. This could take an hour or more but do try to keep going – being free of the anxiety will be worth it! Likewise if the task is to throw away an item it must be thrown away in full, or destroyed so that it cannot be retrieved. If the target is to walk away from something without checking it's very important not to steal one last glance.

Target	Repeated Exposure and Outcome	Level of Anxiety
1. Sit on a bus seat (without covering it first) and no washing hands.	1	
	2	
	3	
	4	
	5	
	6	
	7	
2. Use a public toilet daily.	1	
	2	
	3	
	4	
	5	
	6	
	7	

Target	Repeated Exposure and Outcome	Level of Anxiety
3. Handle dirty laundry every day for a week. Do not wash hands after.	1	
	2	
	3	
	4	
	5	
	6	
	7	

It is useful for all tasks to be entered into a chart like the one above which allows for records of progress to be kept. This process is often likened to climbing up a long ladder. We always start at the bottom and only move onto the next rung when we feel comfortable and safe on the one below.

Further Guidance for Exposure and Response Prevention.

- Make each exposure event as challenging as possible. For example don't just touch a dirty milk bottle – rub your hands and clothes all over it! Don't just reduce the time for a ritual, stop it altogether!
- Make clear predictions beforehand based on Theories A & B. Review these predictions at the end of the task and conclude, based on the evidence, which theory has the greater truth.
- Prolong the exposure until your level of anxiety has reduced significantly – preferably to less than 20/100.

- Repeat the task frequently, ideally several times a day.
- If the exposure doesn't make you highly anxious then increase the requirements of the task until it does.
- Do not do anything to try to reduce your anxiety – this gradual reduction must be allowed to happen naturally.
- Do keep records. These will be a huge source of encouragement as you make progress.

Imaginal Exposure

There will be times when direct exposure to obsessional fears will not be possible. This is usually the case for people who suffer from recurrent and vivid mental images that the person finds horrific. Examples may include seeing a loved one involved in an accident, grabbing a child from its pram, imagining oneself making a racist remark in a meeting, knocking down a cyclist or causing a car crash. In such circumstances the thought suddenly intrudes, the person assumes responsibility for doing something about the thought, their anxiety rises rapidly and they become desperate to try to think about or focus on something else so as to neutralise the image and anxiety. These neutralisation strategies often include mental rituals such as counting backwards, trying to conjure up a 'good image', or reciting a prayer or 'special' sentence.

These strategies are exactly like trying not to think about a white bear! Attempts to suppress specific thoughts and images will inevitably increase their frequency. However, the White Bears experiment demonstrated that trying hard to hold on to an image or thought meant that it would quickly fade away. This is exactly what we are trying to do using imaginal exposure. However unpleasant the image may be, however distressing, there is strong evidence that learning to tolerate this and to continue to focus on it will lead to a significant reduction in frequency and distress.

Exposure to images can also be conducted using a hierarchy if the person has a number of such images, either totally different or variations on the same theme, causing increasing distress. However, some people may only have one type of recurrent image and therefore the exposure remains solely focused on this.

The first task in imaginal exposure is to describe the imagined event in minute detail. It is very important not only to focus on the obsessional image but also the events after this and most importantly your responses to it, in which you may feel responsible or imagine that you may be blamed. Try hard to imagine your guilty feelings and the reactions of other people predicted by the obsessional thoughts. This material is reconstructed frame by frame more like a film than a picture. The task is to vividly recreate the worst case scenario with every colour, sound, smell, and feeling. The person imagines themselves fully engaged and responding to it and not observing the scene from the outside.

If, for example, your image is of snatching a child from a pram: *Try to see the pram and the baby dressed up or covered in blankets, what colours do you see? Describe the mother, the situation in which you find them, the bystanders. Imagine grabbing for the child, the scream of the mother, the screaming child, the intervention of the passers-by, you running off with the child. The sound of police sirens, your capture and arrest, the police cells, staying overnight in custody, your appearance in the morning before the magistrates*. In all of this the essential components throughout this narrative relate to what you are thinking and feeling.

Likewise, if you are obsessed with a fear of knocking down a cyclist. *Imagine you're driving and see a cyclist ahead of you. What is the weather like? Where are you going? What sounds are you listening to? You hear a thud, you look in the rear view mirror and see the cyclist lying in the road, you feel the horror, you pull over and rush to the aid of the cyclist. He's lying motionless, head bleeding. Passers-by gather round you hear them saying you were going too fast, driving too close. An ambulance arrives followed by the police. The cyclist is carried away on a stretcher, blue light flashing and sirens blaring. The police ask for witnesses, people are accusing you, it's your fault. The police ask you to come to the police station to make a statement*……. And so on, wherever your imagination and feelings takes you.

Of course this is a difficult and unpleasant task for anyone to do. But if you think about it, your obsession is causing you to go over and over this

material anyway. However, now you are taking control in order to defeat the obsession. It is very important that we don't trick ourselves into believing that we are somehow tempting fate or making the event more likely. Think about it for a minute, can you really make things happen just by thinking about them? Try it with your lottery numbers!

Usually it is helpful to write down the obsessive image, perhaps several times, until every detail is present to accurately represent your worst imaginings. This in itself is a form of exposure and will be part of the therapy. It is important to follow the image through, seeing the consequences of the actions in all of their imagined horrific detail. This is obviously a very difficult and emotionally demanding exercise and may require several attempts before it will be complete.

Once complete, its is important again to make written predictions about the rehearsal of these thoughts and images based on Theory A and B. Will this add to my dangerousness and make catastrophe more likely (A) or will I become anxious and gradually learn to manage this anxiety (B).

The task is then to repeatedly go over the image in a structured way. First, get comfortable, somewhere where you won't be disturbed for up to an hour. Obtain a tape recorder and then read out loud, slowly recording the script of the image that you have prepared. Don't rush through this. The tape will be used subsequently to guide you through the image. If you go too quickly you'll have difficulty keeping up with the tape. Ideally the tape should last at least 20-30 minutes. The more detail that you can achieve and a slower recording of the material should ensure longer and better exposure. At the end review the evidence for Theory A and B. Which theory was best supported by the outcome?

This same method can be used for exposure to words or phrases that recurrently intrude into a person's thoughts and cause intense distress. Examples include *'I give my soul to the devil. I am damned, I am evil'; 'My family will die today. It will be my fault' 'I am a dangerous pedophile. Everyone will know and revile me'*. Make a recording of these words repeating them exactly as they are experienced and with as much meaning

and emphasis as you can achieve. Do not modify them in any way or introduce any other responses to the thoughts or any other aspect of neutralising onto the tape. Repeat them with a gap of around 30 seconds 50-100 times. The gap is to allow you to focus on the consequences of having these thoughts and the meaning of them to you. It is exactly these meanings and imagined consequences that cause the anxiety. Then exposure yourself regularly to this material in schedules of approximately 45 minutes, until you have found that your anxiety from hearing the material has lessened significantly. Alternatively, you may be able to obtain a 'loop tape', the sort that is still used in pre-digital answering machines. This can avoid having to repeat the words or phrases as much.

Allow yourself sufficient time for the repetition of the tape to gradually lead to a significant reduction in your anxiety. Initially this may take several repetitions lasting perhaps one or two hours. Remember you are facing your worst thoughts and their consequences, and teaching yourself to tolerate the discomfort and distress – it will take time! However, with daily practice you will find that the images and thoughts gradually lose their potency to cause you distress, the anxiety is less intense and reduces more quickly. At the end of the session make some time available to go through relaxation exercises for 10-15 minutes (See later instructions).

It often helps people to see the gradual improvement by keeping a record of their level of anxiety during imaginal exposure. Keep a clock near and at intervals of say 5 or 10 minutes you may like to write down the level of distress you feel on a scale from 0-100. With consistent practice these numbers will soon reduce.

Some people find that use of a tape is limiting or distracting and they prefer to go through the material either by talking through their images or imagining this. You may wish to experiment as to which technique works best for you. Likewise don't worry about the recording of anxiety levels at intervals if you find this too distracting. Just record these at the end of the practice instead, to plot improvement.

It is very important to continue with the process in each session until

exposure causes only very minimal anxiety. It is also essential that no neutralising behaviours creep in to the exposure session. Be very aware of past avoidance or neutralising strategies and remain vigilant for them. The whole process may require 25-30 repetitions of exposure. However, it does mean that within one month of consistent practice the image or words that so affected you will at last, no longer be a threat. Finally, do not forget to review the evidence for Theory A and B at the end of each session and draw conclusions as to which is true based on this evidence.

Remember, facing up to fears whether in reality or in imagination will inevitably cause anxiety. That's the whole point! Your task is to learn to permit anxiety and then to tolerate it for as long as it takes to subside. It is absolutely certain that no harm will come to you as a result of this anxiety. It may feel awful at first –<u>BUT this can be tolerated</u>!

Techniques to Help Reduce Neutralising

It is essential to use exposure and response prevention in order to fully overcome the OCD problems. Neutralising strategies or compulsive rituals have often become part of the sufferer's life, they seem to happen instantaneously and have taken on a life of their own. Though repeated exposure to specific worries will extinguish anxiety, the neutralising rituals, if not specifically dealt with, may well become evident again when new worries develop. Also, if they continue to disrupt your exposure and distract you from feared situations you cannot extinguish this fear. The ideal scenario is simply to stop neutralising and compulsive activity altogether. However, where this is very difficult the following suggestions may be useful in initially modifying it's potency.

1. Altering the picture in your mind

If for example, you have a repeated neutralising strategy of imagining a 'safe scene' then try to continually change this. The sillier the new images the better! There is good evidence that repeating these procedures, whenever the neutralising image comes into your mind, will lead to a gradual reduction in both anxiety and reoccurrence.

2. Singing the words you use to neutralise

Take a familiar tune and set the words you keep repeating to music. Sing them to yourself. It is amazing how different the words or phrase can feel when we treat them in this humorous way. One thing to remember is to make sure you keep changing the tune, so that this doesn't become stuck in your mind!

3. Refocus the mind

Try closing your eyes and focus in your mind on the word 'CALM' whenever the urge to neutralise occurs. Try to actually see the letters of the word written in different colours and different types of print and handwriting. Each time you breathe out just say the word CALM to yourself while letting the tension drain out of your body. Use this technique throughout the day, not just when you want to distract yourself. Just a few minutes each time can make a great difference.

4. Set aside some worry time

Instead of trying to banish obsessive anxiety with compulsive rituals decide to postpone the worry to an allocated slot later in your day. Decide exactly when and for how long you're going to worry for a set time each day. Then delay all worry until this time – say to yourself '*I'll think about all this later'*. Instead of trying not to be obsessive, try to cram as much obsessive thoughts as you can during this specified time. Dwell on the bad, don't try to stop or change your thinking let it all out. It is often useful to use an alarm clock to signal the end of the worry time. People often find that they can stop themselves from worrying if they know that they can postpone the worry to a specified time. However, by delaying this process, when the allotted time comes the worry has often become irrelevant or hard to remember.

5. Speed up / Slow down / Distort

Whether the neutralising strategy is a word, sentence, phrase or image it is possible to manipulate in many ways. For instance, saying the ritual quicker or slower or playing through the image in slow motion or at high speed can radically change your attitude to your thoughts. Reciting the ritual in a silly accent, speaking, very quietly or loudly, or imagining the words coming out under water can also help. Images can be made lighter or darker or given a blue tint etc. Other details can be introduced to the neutralising images to ridicule them. There are numerous other ways of making significant changes like this limited only by one's imagination.

6. Time limit the ritual

This involves using a stopwatch, egg timer or by consistently counting (and not slowing down to prolong the event!) to reduce the time allocated to any compulsive behaviour or mental rehearsal. Be very strict with yourself, gradually shaving time off the routine and then stopping, even though you will not have completed the task entirely to your satisfaction.

7. Add a consequence to the ritual

By making the performance of rituals very frustrating you can reduce their frequency. For example, if you fear inadvertently knocking a cyclist of his bike and repeatedly turn the car round to check the road for distressed cyclists, then you might add a consequence of having to turn left at the

next two sets of traffic lights. Obviously this would be very inconvenient and might make you think twice about giving in to the earlier urges. Other examples might include; washing hands and then being required to deliberately touch the toilet seat, performing the ritual of counting backwards in threes from one hundred and then as a consequence, having to add in fours to two hundred. One author even suggested paying a fine for each reproduction of a ritual and then donating the money to your least favourite organisation!

INCREASING AWARENESS OF OBSESSIVE THINKING

As we noted earlier some research has shown that many people with OCD have a distorted view of their personal responsibility. They may question the things that they have said, done or failed to do, believing that they may have unwittingly caused harm or put themselves or others at risk. This biased negative thinking leads to anxiety and compulsive behaviour aimed to either try to convince themselves that no harm has been done or to try to neutralise the worry in some other ritualised way.

A vicious cycle is set up: The more anxious you become - the more negative thoughts you have - the more you believe in these thoughts - the more anxious they make you. The first stage in breaking down this vicious cycle is learning to become more aware of unhelpful patterns of thinking and of the effect that it is having on you. Every time you find yourself thinking in obsessional ways, note down what may have triggered this and exactly what you're thinking on a chart similar to the following one:

Situation	Intrusive Thoughts	Obsessive Thinking
e.g. Driving to town to go shopping, passing a cyclist.	Did I knock him off his bike?	I must go back and check he's OK. I need to know he's safe. It's my fault.
e.g. Sitting at home in the lounge.	Our new neighbour is very attractive.	I'm being unfaithful to my wife. I must tell her everything. I'm ruining our marriage.

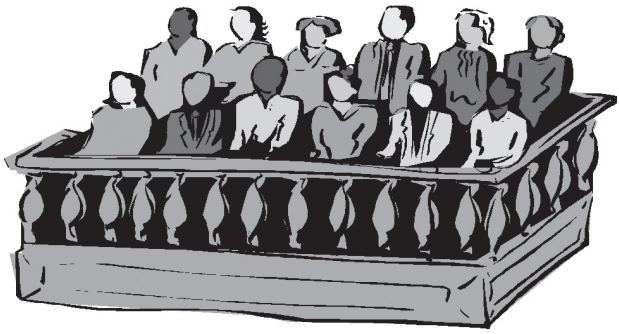
Situation	Intrusive Thoughts	Obsessive Thinking
e.g. Putting weed killer on the lawn	This could kill someone if they swallowed it.	I must stop anyone going near the lawn. I'd be responsible if someone became ill.

CHALLENGING OBSESSIVE THOUGHTS

Once you have learned to become more aware of your patterns of obsessive thinking the next step is to re-examine your thoughts and to look for more helpful and realistic ways of thinking. Consider the following ways of questioning and altering negative thoughts;

1. **What is the evidence?** - Do the facts of the situation fully support the view we have taken? Am I confusing a thought with a fact? Would my reasoning stand up in a court or be accepted as true by other people? Am I jumping to conclusions?

Automatic thought	**Possible alternative thoughts**
e.g. I have to wash before making anyone a drink. My hands could be dirty and I'll make them ill.	My hands are clean enough. Other people don't wash before making drinks.



2. **What alternative ways of looking at it are there?** - How else could you interpret what has happened? or how would someone else view this situation? Try to think of as many different alternative views as you can and think about what evidence exists for each possible idea. There are always lots of different ways of looking at any event. If you could consider things objectively ask yourself which is the most likely?

Automatic thought	**Possible alternative thoughts**
e.g. I must keep the newspaper just in case I need it at a later date.	*Let it go. If I ever really need the information I can source it elsewhere.*

3. **What is the effect of thinking the way you do?** - How does it influence the way you feel and what you do? What are the advantages of thinking in this way? Can you find an alternative view that will have a more positive effect?

Automatic thought	**Possible alternative thoughts**
e.g. I must control the way I think at times. It's my responsibility.	*We all get odd thoughts at times. They're not important, don't worry.*

4. **What thinking errors are you making?**
People with obsessional problems often distort their thinking in particular ways. These typical thinking errors are listed in the following section. Try to identify which error you may be making and which errors you make most often.

- **Thinking in extremes**
This is also known as 'black and white thinking'. A person may say *"If I can't have total control then there is no sense risking it"* or "*Either I'm clean or I'm dirty*". There are no grey areas in this type of thinking - everything is categorised as either one of only two possibilities. The key challenge to this type of thinking is to identify the grey areas, i.e. the many steps that lie between the extremes.

- **Magnification and minimisation**
  This is the process of focusing selectively on the relatively minor things that have gone wrong, blowing these totally out of proportion. E.g. "*I saw a needle the other week. What if I stepped on it without knowing about it? What if I've contracted HIV!"?* This intense magnification of an event is made all the worse by minimising the facts: There was no acute pain that would come from standing on a needle, HIV is very hard to contract and impossible from very old disused needles.

- **Personalising**
  This is where the person makes themselves responsible and guilty for an event which was nothing to do with them. E.g. *"I saw a rock in the road yesterday and didn't move it. I'm sure it has caused a fatal accident. It will be all my fault"*. None of us can take responsibility for the safety of all others. No-one else would dream of blaming us in these circumstances. Life is a series of risks. We can't change this.

- **Imagining catastrophes**
  The person repeatedly imagines disaster in even the most ordinary intrusive thought. E.g. *"I've just had a violent thought. It must mean I'm a dangerous person and I may lose control at any moment"*.

- **Double standards**
  People with OCD rarely criticise others for not being obsessional. They do not go into other people's homes and complain about the lack of cleanliness, the casual approach to locking up, or the lack of order. Additionally, OCD sufferers rarely implore others to wash and check or perform rituals to avert contamination or disaster and are often apparently content with other people – even those dearest to them- touching object or performing tasks that they are terrified to undertake themselves. Additionally, when local or national disasters occur they never assume that other people's intrusive thoughts were responsible.

- **Demand statements**
  These include the words: should; must; ought; have to.
  The person criticises themselves for not following to the letter rigid and impossible rules for life. Examples include "*I should control my*

thoughts", "*It must be important because I think about it. I think about it because it must be important"*.

More about Styles of Obsessive Thinking and How to Challenge Them

Some researchers in Canada have tried to summarise the different patterns of obsessive thinking that patients present with. They note the importance of exaggerated responsibility for many OCD suffers but also highlight a number of other broad groupings of faulty beliefs;

1. Overestimation of the importance of the thought and its implications. A belief that thoughts will necessarily lead to specific actions or outcomes. A belief that our thoughts have magical powers to bring about unrelated events.

Examples of this type of thinking include the following circular reasoning: '*It must be important because I think about it. I think about it because it must be important'*.

In order to challenge this idea it is often useful to stop every so often in the day and just try to think through what you have been thinking for the past few minutes. Unimportant thoughts occur all the time, intrusions into our mind are very often entirely random and entirely senseless. It's not the thoughts that are the problem, it's the meaning that we give to the thoughts. Remember the White Bears experiment - random thoughts can become important and reoccur just because we don't want them and we try not to think about them.

- Exaggerated Personal Responsibility

We have already looked at this proposition. The first step is to try to establish awareness of where the person takes responsibility. A good method is to try to fill the blanks to following:

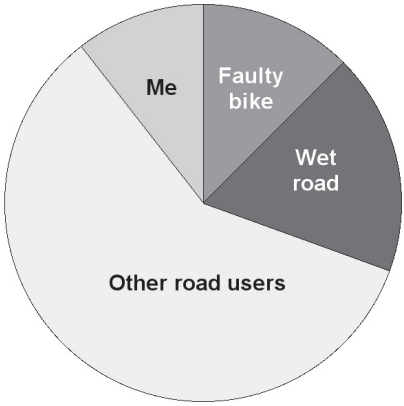
I might see or do something like.....……..... which will mean that .....……..... will happen and therefore I'll be held responsible and feel guilty for ever.

Some examples of this type of thinking relate to being responsible for every plug socket in the office, making sure they're turned off with the switch down or that any electrical item is disconnected. If this is not done the person might believe there is a chance of an electrical fire and they will be deemed responsible for this by their colleagues.

Others fear that they may have inadvertently knocked a cyclist off their bike, or accidentally dropped something into the cup of tea they've made or cake they've just baked. Usually these obsessional thoughts lead to an array of checking behaviours, going over and over again the same events to try to create a certainty in their own mind that these things haven't happened, or constantly re-doing the task until exhaustion sets in.

It can be helpful to try to think through our worst fears in detail and rationally decide who or what might be responsible if the worst did happen and something went wrong. A good way to do this is to draw up a 'pie chart' of responsibility:

What if the cyclist was knocked off his bike?



Obviously we all of us have a responsibility to other people to behave sensibly but there is a vast difference between being a good citizen compared with wanting to be everybody's guardian angel. There is some risk in every action we perform. The task for people with OCD is often to

learn to accurately assess these risks so that the behaviours associated with them can become normal again.

Other people with OCD may believe: ***'Thinking is as bad as doing'. 'If I think about it this means I secretly or unconsciously want to and will do it'***. '

The first thing to say about these types of thought is that intrusions are not optional. We frequently do not choose what comes into our mind - its often random. However, we do have a choice about how seriously to take each of our thoughts and whether to act or not act on them. This choice is a conscious decision that we take having weighed up the consequences of our actions. It would be impossible to go through the complex series of behaviours that are involved in carrying out our thoughts, without being fully aware of what we are doing and without being fully committed to the action. People who experience OCD do not do dangerous, violent or anti-social things any more than any other conscientious member of society.

The third style of thinking within this category relates to a belief in ***'magical thoughts'***. Some people experience unpleasant thoughts such as images of a loved one in a car accident, or a baby falling out of their pram. They then convince themselves: - *'It's bound to happen if I keep thinking about it'*. This is a belief that one has the power by thinking in a certain way, to actually influence or change events. This often leads the sufferer to engage in a specific pattern of thinking or behaviour to *'undo the magic'* and prevent the disaster. They feel that they cannot take the risk of not doing this because the stakes are always too high.

Of course bad things will happen to all of us at some time but not because of something we've thought. We must try to remember that there is no relationship between our thoughts and external events that occur independent of us. Do you think that if you think that the goldfish is ill for long enough it might die because of your thinking pattern? Can you break the toaster by thinking it's not working? The key to challenging this type of thinking is to deliberately invoke the 'magic thoughts' and resist any attempt to neutralise them - they're just thoughts!

2. Need for certainty and completeness

Some people can become obsessed with needing to know. Something jogs their memory and they feel sure they should or must remember an event or something they've read. They spend hours searching though old diaries, or sifting through old newspapers they've been storing up over many years for this very purpose. They ring friends, family and organisations to ask the most trivial questions to try to get to the answer to the problem, trying all the time to find relief from the anxiety of not knowing.

This problem fuels itself. The longer the search goes on the greater is the feeling of anxiety, the more anxious we become the more we struggle to find the answer to relieve the anxiety! The fact that the question is pointless, trivial and unimportant has been lost. The person is caught up in the pursuit of the answer to relieve the anxiety - the actual question has become irrelevant!

It is often useful to specifically write down answers to the following questions as soon as we become aware of the obsessive thought.

- What possible advantages will I gain from knowing the answer to this question?
- What disadvantages might come from trying to seek the solution?
- What will happen if I can't find the answer?
- How is my life going to be different by knowing this answer?

It is helpful to remind ourselves that there are very different requirements to memorise different types of information e.g. junk mail Vs reading novels Vs exam material. Each requires a totally different level of analysis and memory.

No-one has perfect recall and human beings are supposed to forget things - particularly unimportant things. There are many more fruitful ways of occupying our minds than seeking out useless facts.

Another good method of directly challenging this irrational behaviour is to compile a list - 'Things I didn't need to know'! Add to this list frequently!

3. Overestimation of probability and severity of consequences of negative events and underestimation of ability to cope.

People who suffer from OCD often have great difficulty accurately assessing threat. Although most people assume a situation is safe unless it has been proved to be dangerous, most OCD sufferers seem to assume danger unless proven safe! They fail to learn from previous situations in which they feared danger and were proven to be wrong and have great difficulty not assuming that *'this time is different'*. Despite endless false alarms, the person rationalises that it is their own vigilance that has kept them safe, not the fact that the situation was inherently safe.

Once the person convinces themselves of possible danger; they mentally collect examples of events consistent with this fear. For example any person who compulsively checks his car is locked, will automatically register any reference to a car theft in the paper or on the television. This 'selective attention' leads to the assumption that the event is far more common that in fact it really is.

The key to challenging this type of thinking lies in reassessing the risk. By learning from our experiences and from accurately assessing the reactions and behaviour of others, we can learn to think differently. In so doing, it becomes possible to realise that the event that we had spent so much time and energy seeking to avoid is often a million to one shot. It is also important to face the fear. Though we would hate it to happen, we must also realise that people do cope with disaster however traumatic.

4. Need for absolute control.

Some people persuade themselves that they must rigidly control their thinking. They might put forward a moral argument, or believe that failing to control thinking will lead to insanity or irrational consequences, or they might believe that controlling thinking is an ultimate form of self-knowledge and self-empowerment. When we consider the earlier evidence for the random nature of intrusive thoughts, and add to this the White Bears evidence, then we realise that none of the above ideas can possibly be correct. Such notions must therefore be vigorously challenged, giving up the need for control to 'free the mind'.

5. Belief that anxiety caused by the thoughts is intolerable or dangerous.

This may be an irrational belief in one's ability to tolerate anxiety or an overestimation of the levels of anxiety that are possible. Some people fear that their levels of anxiety will become so high as to lead to loss of mental or behavioural control, sickness, craziness or death. Such ideas can be a significant barrier to getting started with self-exposure techniques.

We must remind ourselves that anxiety symptoms, caused by adrenaline, are a normal bodily response to danger. What we experience is the body preparing to cope with danger either by 'fight or flight'. This process is instantaneous once the adrenal glands are triggered to release adrenaline into the blood stream. We immediately need more oxygenated blood in the muscles of our arms and legs for running and fighting. Therefore we breathe faster to take in this oxygen and the heart rate speeds up to pump round this oxygen rich blood. Blood is selectively pumped from the head chest and stomach to where it's needed more - in the muscles. This can cause temporary feelings of light headedness, nausea and indigestion. Muscles being engorged with blood can also feel strange and people often describe a tingling and other sensations. The body needs to be as agile as possible so adrenalin can also make us feel the need to suddenly use the toilet. Don't worry!, you will get there in time - our control of our sphincter muscles allows us to hold on. You will often sweat as a result of this flight fight mechanism. The sweat cools the body in combat and makes the body more slippery for the foe to grab hold of.
It is essential to realise that none of the above symptoms can harm you. If the mechanism caused us to faint, go mad, die, etc. Then we would never have survived as a species since we would have been 'easy meat' for any predator. In fact, it is exactly the effectiveness and efficiency of the flight-fight mechanism that ensured our survival. Despite the fact that we no longer share our personal spaces with freely roaming wild animals, it will take hundreds of thousands of years for this mechanism to be genetically de-selected – so we're stuck with it!

Ways of Re-Construing the Obsession

Some people find it helpful to try to imagine their obsessional problems in a particular way to help them distance themselves and resist the urge to behave compulsively. The following are some examples of the methods people have shared.

The School Bully's Propaganda

Your OCD is like a playground bully trying to intimidate you. It is constantly seeking to blame you for things that might happen that are impossible or entirely unconnected to you. It also feeds you a propaganda that your thoughts are abnormal, wrong or dangerous, that you should work as hard as you can to make up for these and suffer in the process.

At some point we all have to stand up to bullies. When we do we inevitably find that they back down and slink off. By learning to say "NO!" to your OCD and refusing to be intimidated by it any longer, you will gain control over it.

The Parasitic Obsession

Some OCD sufferers find it helpful to imagine their obsessional problem as a parasite that feeds off their energy. In order to kill the parasite you must do battle with it and starve it of energy by not doing what it's telling you to do. Don't give in to it's demands, don't give it your time, attention and your energy - without these things it will starve and die.

The Obsession as Energy in a Balloon

Try to imagine the obsession as like a balloon inside of you, full of energy. The more energy you pump into it the bigger the balloon becomes. Your specific symptoms of obsessions and compulsions are like tiny holes in the balloon through which huge amounts of energy are released – this is your energy invested in the obsessions! Trying to deal with the specific obsessions themselves is important but it is not enough. That would be like putting your fingers over the holes - others holes might then appear with new obsessions developing. The most important task is to cut off the energy supply to your obsessions. Deflate the balloon!

In order to win this battle to deflate the balloon and resist the obsessions, there are a number of techniques that you can learn that can help in addition to the exposure and response prevention strategy discussed earlier. The following section describes these methods in detail. There is no magic in any of these methods. They all require practice and hard work to make them succeed. Some methods will make more sense to you or suit you better but all of them will require perseverance and practice.

OTHER WAYS OF MANAGING OCD

General Energy Tapping Methods

Physical Exercise

One of the most immediate ways to divert our energy is through physical exercise. Studies have shown that aerobic physical exercise, the sort that significantly increases our heart rate, is a very important strategy for reducing muscle tension, relieving frustrations, lifting mood, improving self esteem and generally making us more healthy. Under states of high stress we should be eventually aiming for half an hour a day of this type of vigorous exercise which significantly increases our heart rate. If you haven't been used to regular exercise you must start slowly. If you have any physical health problems that might be made worse by vigorous exercise then you should discuss this with your GP first. It is helpful if you

can vary the type of exercise taken to be using different muscles, but most importantly the exercise must be vigorous and prolonged for around 30 minutes. Examples include; jogging; cycling; swimming; squash; badminton; exercise classes; gym work etc.

It is often useful to conduct exercise with a partner, a group, or in a club. This can help to motivate us when we don't feel like doing it. People often report feeling too tired to do exercise. This tiredness can often occur as a result of chronic muscle tension in people with stress and anxiety problems. Here the muscles are in constant use from the tension, as though you have been running up and down on the spot all day. Vigorous physical exercise will help to reduce this tension and thereby give you more energy.

Once you begin to commit yourself to this form of activity the rewards will quickly become apparent. Exercise has also been shown to raise mood levels by altering the chemicals in our brains, making us generally feel more positive and mentally stronger. One of these chemicals is **Serotonin**, which we looked at earlier. Exercise increases the availability of Serotonin in similar ways to prescribed medications that can help obsessional problems.

Social Activities

Seeking out the company of others is a very powerful way of distracting us from focussing on problems. We get a wider perspective and can take a broader view when we're engaged with the world around us rather than being isolated in our distress. Try to cultivate hobbies and interests that will necessarily include other people. Examples might include book clubs, team games, evening classes, film clubs, higher education etc.

Relaxation Methods

Relaxation is an excellent method of deflating the balloon by reducing the excessive energy in the body that causes agitation and tension. Relaxation is also incompatible with feeling anxious; you can't feel both at once. Though there are many forms of relaxation including yoga, meditation, using imagery, hypnosis etc. The method favoured by many psychologists is called 'progressive muscular relaxation'. This involves a series of tensing and relaxing exercises throughout the muscles of the body. Relaxation is a skill. It must be practised initially daily for at least a month and then as required. It can be performed sitting or lying down, in a quiet room with dim lighting where you won't be disturbed

When we tightly clench the muscles of the hand by making a fist, two important changes take place. First, the muscles become hard and tighten around the bones of the hand. Second, the brain is signalled that the muscles of the hand are being used and therefore need blood rich in oxygen to make them work effectively. When this exercise is stopped by unclenching the fist and allowing the hand to become loose, suddenly these processes reverse. As the extra blood withdraws a slight tingling effect is felt, and the muscles become loose and relaxed; now hanging on the bones of the hand as though dead weight. This creates a sensation of warm heaviness. As each exercise is conducted for all of the muscles of the body, heaviness spreads until the whole body feels calm and pleasantly relaxed.

There is a specific tensing exercise to learn for each area of the body. This is held for approximately 5 seconds. The body area is then allowed to relax by immediately letting go of the tensing exercise. The relaxation is allowed to continue to develop for approximately 15 seconds before the next exercise. Each area is tensed twice before moving on. The sequence of exercises and the methods of tensing used are as follows;

1. Right hand	Squeeze the right hand tightly into a fist.
2. Right forearm	Straighten the right arm and bend down the hand as far as you can.
3. Right biceps	Force the knuckles of the right hand onto the right shoulder.

4. Left hand	Squeeze the left hand tightly into a fist.
5. Left forearm	Straighten the left arm and bend down the hand as far as you can.
6. Left biceps	Force the knuckles of the left hand onto the left shoulder.
7. Forehead	Raise up the eyebrows or frown hard.
8. Eyes	Screw up the eyes tightly.
9. Mouth, cheek, Jaw	Clench the teeth and stretch the mouth as though in an exaggerated smile.
10. Neck	Gently bend back the head as far as you can, or press the chin onto the chest.
11. Shoulders	Force your shoulders back, or forward.
12. Chest	Take in a deep breath and expand the chest.
13. Stomach	Suck in the stomach under the rib cage.
14. Right thigh	Straighten the right leg.
15. Right calf	Curl up your right toes towards your face.
16. Right foot	Curl down your right toes and bend down your right foot.
17. Left thigh	Straighten the left leg.
18. Left calf	Curl up your left toes towards your face.
19. Left foot	Curl down your left toes and bend down your left foot.

Both at the beginning and the end of the exercises it is also helpful for a few minutes to focus the mind on the word '*Calm*', or another similar soothing word, each time you breathe out. This word will gradually become a direct cue to feelings of relaxation. This word can then also act as a powerful method of distraction, closing your eyes and focusing on the word '*calm*', if you begin to feel anxious.

Mindfulness

This is a form of meditation that aims to teach greater acceptance. It involves learning to focus on the present moment, recognising everything intruding upon your senses and thoughts and just allowing them to be, without judging or trying to change anything. Mindfulness helps teach us detached observation, to tolerate distress without getting caught up in it.

Distressing thoughts will come into your mind but Mindfulness will help you to recognise these and allow them to pass without getting caught up in the anxiety or in futile attempts to neutralise the thoughts. In this way obsessive ideas can be seen as no more important than 'clouds floating by in the sky of the mind'. Mindfulness can be learned in a group or from a CD. Try the Internet for further help with this or ask your local mental health service for advice about local resources.

The Use of Medication

It is certainly not necessary to take medication to manage OCD but many people report that a combination of medication and CBT strategies has helped them greatly. Most people who take medication for OCD will say:

> '*It didn't stop me having obsessional thoughts but it did help me to resist them. They seemed less important*'.

Amazingly, it has been estimated that 50% of patients fail to take their medication properly. This will undoubtedly mean that it is less effective and will lead to the person becoming frustrated at their slower rate of improvement.

If you do decide to take medication remember the following advice:

- The specific dose of the medication is adjusted to suit you. It may take a while before the dose is exactly right. Be patient and try to persevere.
- This type of medication can take 2 weeks to start working and may not be fully effective for a few weeks after that.
- It is essential to take the medication every day, exactly as prescribed, not just when you feel you need it.
- There are a number of tablets used for treating OCD. Each is slightly different and one may suit you much better than another. Be prepared to try something different if necessary, rather than just give up.
- Many people experience unpleasant side-effects when they first take the medication. These problems will often improve after a short while. If the side-effects are tolerable then try to persevere with the medication. If not, advise your GP and perhaps try something else.
- It is common for people to be taking medication for several months in

order to stabilise their mood and help them establish control over their symptoms using CBT strategies.

- When eventually coming off the tablets it is essential to withdraw slowly. This is achieved by gradually reducing the dose over several weeks or by systematically taking the tablets less frequently. Always take advice from your GP on this process rather than just stopping the tablets yourself.

ADVICE FOR FAMILY MEMBERS AND FRIENDS

Obsessive and compulsive problems are often very hard for non-sufferers to understand. It almost seems impossible that the human mind can be so powerful to be able to convince intelligent, rational people to be fearful or doubtful in such obviously unnecessary ways. People who have obsessional problems themselves can often look at another sufferer's problems and think them bizarre.

OCD from the Inside

"The closest I can come to describing it is to imagine that you are going on a fabulous holiday of a life-time, somewhere you've always wanted to see. You wake up on the morning of the holiday and your alarm hasn't gone off! You've got just enough time to get to the airport to catch the flight. You call a taxi and he arrives 10 minutes later than you'd been told. You get out onto the motorway and there's been an accident. Traffic is solid and crawling along. Eventually you arrive at the airport, the flight has been delayed, your going to make it after all - and then you discover that you haven't packed your passport!."

"It's like someone has covered you in Golden Syrup. You just can't bear it, you just have to go an wash and wash until it's all gone but you can't get it off, you cannot stop the horrendous feeling of being sticky, it will not go away."

"You're racked with guilt. You know that the very worst is going to happen. It's inevitable and it's all your fault. You can see the anger and blame in their faces, and it's all directed at you. You are the pariah, you alone are responsible."

"You don't want to think about it but you have to. There's no choice. The only hope is to continue to wade through the treacle of thoughts until it stops, until the brain gives up and the pain goes away."

"I just cannot walk away. Part of me knows the door is locked but I just cannot trust this enough. I'm compelled to return, to pull the door as hard as I possibly can. But was it really locked? Really, truely locked? What if I've left it open? Is it open? It's open! I have to return... And now I'm really late and getting more and more anxious."

"…..And then I have to touch the cupboard door with the left and right index fingers just so and count to nine. Then I space out all my shirts at exactly the right distance and close the cupboard door nine times or 18 or 27, until it feels right. And then……..."

We must never trivialise OCD problems as a weakness of will-power or a lack of logic. I would guess that you have spent hours trying to convince your family member or friend who has OCD that there is nothing to worry about. This approach is very difficult and frustrating and often fails without specific training in helping the patient to challenge these beliefs.

It is very easy for family members and friends to get caught up in the OCD problems. Perhaps you have been asked to check things or keep things spotlessly clean or tidy, or continuously reassure in some other way. Although you will want to do everything that you can to help, giving in to these strange requests in these ways is definitely not helpful. If we collude with the person's problems we end up making them more an everyday part of life so that in the end, the whole family are behaving in ways that we might describe as obsessive and compulsive. In addition, complying with the person's obsessive demands or compulsive behaviour can legitimise

the requests and reinforce the illogical ideas by enabling the sufferer to conclude that there must be some truth in the worry or value in the behaviour, since other people are behaving compulsively too!

The key to helping the patient is to make them fully own their problem. Though this may seem heartless and even cruel at times, it is essential that the person takes full responsibility for their OCD problems. None of us can overcome a problem for which someone else has become responsible.

This will mean that you may often have to say to those you love: *'The booklet tells me I must not do this'* or '*Professional advice is that I must not get involved'*. You may find the person gets angry or accuses you of not caring, but you should try not to weaken. These problems can be overcome as long as the person fully realises that they alone are responsible for making the necessary changes and being determined to follow professional advice and stick to the programme.

This does not mean that you must ignore the person or be disinterested. It is very important to support, encourage and praise as much as you can, particularly as you begin to see positive changes taking place in the person's behaviour or ways of thinking. If they are following a particular programme, it is often helpful to ask to see the written records, to offer any necessary advice and discuss how things are going. We all need the support, patience and encouragement of others to help us make difficult changes in our lives.

Please read and re-read this booklet yourself. If the person is finding things particularly difficult or seems to be stuck, also encourage them to keep reading the booklet. Understanding the problems is the key to being able to change them. There are very many ideas here that can't possibly all be taken in at any one time. Beyond this, you may wish to advise the person to seek further professional help perhaps from a general practitioner, their therapist or the support of local or national self help groups.

Try to remain as positive as you can. With time and perseverance things will change. Your optimism will be a huge encouragement and support. And if you need help and support yourself don't be too proud to ask.

FURTHER READING - SELF HELP GUIDES

'Overcoming Obsessive-Compulsive Disorder' (2005) David Veale & Rob Wilson. Robinson, London. £9.99.
Offering state of the art theory and practical CBT advice. This is an excellent book.

'Stop Obsessing' (1995) Edna Foa & Greg Wilson. Bantam Books Inc. ISBN 0553353500. ($9.95 Ordered from USA through good bookshops.)
Very useful. Lots of practical methods & techniques for self help. Well worth trying to order this or searching through Amazon 2nd hand section.

'Getting Control' (2000) Lee Baer. Plume Books. ISBN 0-452-28177-6
Leading USA OCD expert. Very practical behavioural/cognitive-behavioural approach. Lots of useful strategy.

'Understanding Obsessions and Compulsions' Frank Tallis. (1992) Sheldon Press. ISBN 0-85969-652-9
Largely-behavioural approach but includes some cognitive methods. Very useful & practical guide to self-help.

HELPFUL ORGANISATIONS

Obsessive Action
A registered charity to help those suffering from OCD and associated disorders, and to advance awareness, research, understanding and treatment of OCD. Members receive an information pack, newsletters and invitations to conferences & workshops. Also details of local groups.
Obsessive Action, Aberdeen Centre, 22-24 Highbury Grove, London. N5 2EA. 'Phone 020 7226 4000.
E-mail: admin@obsessive-action.demon.co.uk
Website: **http://www.ocdaction.org.uk/**

OCD UK
P.O. Box 8115
Nottingham NG7 1YT.
E-mail: admin@ukocd.org
Website: **http://www.ocduk.org/**

AND FINALLY.....

I would be very grateful indeed for a moment of your time to give me some feedback about this booklet. This information will be vital in helping me to revise and improve the content. Would you kindly answer the following questions ***once you have read the booklet several times and tried to consistently use the advice therein***:

	Not at all				***Moderately***			***Greatly***
How helpful was the booklet overall?	0	1	2	3	4	6	7	8
How much more do you understand your OCD problems having used the booklet	0	1	2	3	4	6	7	8
How much more in control of your OCD are you now?	0	1	2	3	4	6	7	8

Which sections of the booklet were most useful to you?

Which sections of the booklet were least useful to you?

Would you recommend the booklet to other OCD sufferers? **YES / NO**

Any other comments please?

Please return your comments to Dr. Simon Enright, FREEPOST RLYE-TKEY-UYKS, Prospect Park Hospital, Honey End Lane, Tilehurst, Reading. RG30 4EJ.

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