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Coping with Obsessive-Compulsive Disorder

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Jan van Niekerk

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What causes OCD and maintains it?

> It is impossible to get out of a problem by using the same kind of thinking that it took to get into it.
>
> Albert Einstein

In this chapter I will introduce you to the cognitive-behavioural model, and what this can tell us about OCD. Next will follow an overview of biological theories and treatments of OCD, and I will compare and discuss the pros and cons of medication and psychological therapy. Finally, I will give an outline of how the rest of the book fits together to help you with your OCD.

Cognitive-behavioural therapy (CBT)

> People are disturbed not by things, but by the view which they take of them.
>
> Epictetus, Greek philosopher

This ancient quote reflects the main idea behind cognitive-behavioural therapy (CBT). Often, different people will

have different thoughts about the same event or experience. The classic example is that of a glass of water filled halfway – one person sees it as half-empty and the other sees it as half-full.

But why does this matter? During or after a situation or event we have automatic thoughts (automatic, because they just pop into your head) about the event. These represent the meaning or interpretation we attach to the event. How we feel (our emotions) and how we choose to respond (behaviour or coping) depend on this meaning. In turn, our emotional response may affect our bodily sensations, for example, when feeling anxious your heart may be thumping and your hands may be clammy and shaky.

Automatic thoughts don't arise in a vacuum. They stem from our *underlying beliefs* about ourselves, other people, the future, the past, and so on, or the *assumptions* we make, or the *rules* we hold ourselves or others to. In turn, our underlying beliefs are influenced by our previous life experiences. This relationship is illustrated in figure 1.

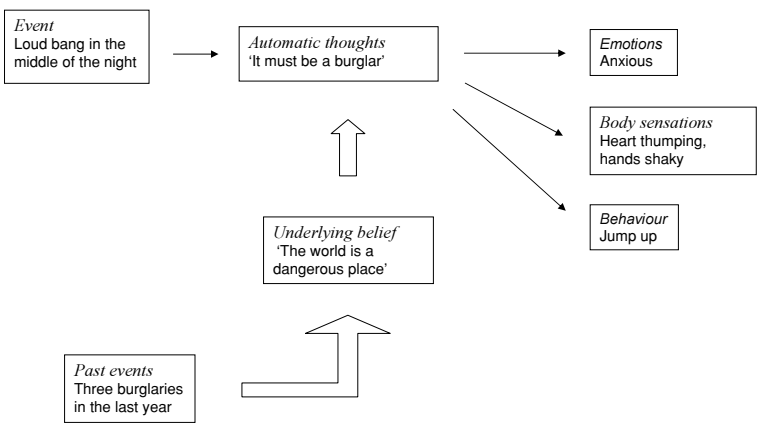

Figure 1 *Situation*: Person lies asleep in bedroom

A few points to clarify

It is important to distinguish thoughts and feelings, as the English language can sometimes confusingly introduce a thought with 'I *feel* that …' A simple distinction is that to express a thought usually requires a phrase or sentence, and an emotion or feeling usually requires a single word (e.g. happy, sad, frustrated, cheerful, relaxed, angry, bewildered, guilty, ashamed, anxious, upset, depressed, low, and so on).

After thinking about the cognitive-behavioural model, you may retort that emotions sometimes precede thinking, such as when feeling low may cause negative thinking rather than the other way around. This is a valid point, and we have to acknowledge that the relationship between mood and thinking can be complex, and that the one may influence the other. This may result in a *vicious cycle* where negative thoughts cause low mood, and low mood in turn invites further negative thinking, and so on. However, for the purposes of CBT, the important point is that thoughts can influence emotion, mood and behaviour. Next we will consider, more specifically, how the CBT model makes sense of emotional difficulties, and then OCD.

How the CBT model can help us understand emotional difficulties

We have established that the *meanings* we attach to events have consequences for how we feel and how we respond. Sometimes these thoughts may leave us feeling disturbed or distressed, as illustrated in figure 1. Cognitive-behavioural therapists believe that people do not have to continue to interpret events in the same way for the rest of their lives. They can learn to think differently about events and therefore be less upset by them.

Most often we have realistic grounds or good *evidence* for what we believe about others or ourselves. However, sometimes our beliefs may rely on a *biased* or one-sided view of

reality, which is a bit like holding a prejudice. A depressed person may remember the person who ignored him but not the ones who chatted to him and conclude, 'Nobody likes me.' In CBT these tendencies are referred to as *thought distortions*, and the problem with this skewed thinking is that by its nature it gives a false view of the world. Here is a list of thought distortions that are common villains leading to prolonged and excessive levels of upset.

Thought distortions

All-or-nothing thinking: the tendency to evaluate your own or other people's performance or personal qualities as black/white. Also called the *fallacy of bifurcation*: presenting only two alternatives where others exist (Pirie, 2006), e.g.

- 'I didn't get the promotion: that means I'm a nobody.'
- 'People are either your friends or your enemies.'
- 'You're either normal or mad.'

The world is *complex*: people or events are usually not just one way or the other. 'Shades of grey' are not acknowledged.

Magnification: a tendency to reach blanket negative conclusions about yourself or other people on the basis of flimsy evidence, e.g.

- After making a single mistake: 'I'm useless.'
- After your boss snapped at you on only one occasion: 'She's horrible.'

You are not reaching a balanced conclusion by looking at *all the evidence* objectively.

Minimization: a tendency to discount any information that doesn't fit with your negative view of yourself or other people, e.g.

- After someone complimented you: 'He's just feeling sorry for me.'

Continued

- After your boss apologized for having snapped at you: 'She just wants something from me.'

You are not reaching a balanced conclusion by looking at *all the evidence* objectively.

Overgeneralization: when you arbitrarily conclude that a negative event will happen over and over again, e.g.

- After one unsuccessful job application: 'I'm never going to get a job.'
- After getting a flat tyre: 'This is just so typical: everything always goes wrong for me.'

You believe that there is a negative pattern that will continue, but when looking at all the relevant evidence, there is no sound basis for such a prediction.

Catastrophizing: dwelling on the negatives in a situation and believing things are worse than they actually are, e.g.

- 'My OCD has ruined my life.'
- After not getting the promotion: 'I'm a nothing.'

You may not be paying attention to aspects of the situation that contradict your negative conclusion (there may well be areas of your life that are relatively unaffected by OCD, and not getting the promotion is not the end of the world!).

Low frustration tolerance: persuading yourself that something is so bad that you absolutely can't tolerate it; this is frequently linked to catastrophizing, e.g.

- 'That he didn't give me the promotion is the most awful thing that could have happened' (catastrophizing); 'it's so unfair and I can't stand it' (low frustration tolerance)!

The reality is that your body and your mind can tolerate much worse. Better to tell yourself that it's not the worst thing in the world, that you can cope with it even though it may be unpleasant, and then deal with the situation calmly.

Inflexible demands: making rigid demands about things out

Continued

of your control (and then catastrophizing when your demand is not satisfied), e.g.

- 'He shouldn't have said that' (and the fact that he did is worse than terrible!).
- 'I must always win' (and if I didn't, that would be the absolute worst thing in the world and I couldn't bear it).

You cause yourself unnecessary upset by failing to recognize that not everything in the world is 100% under your control. Being upset does not help you to cope with the situation in the best way.

Emotional reasoning: when your emotions in or after a situation dictate your conclusion about yourself or the situation, e.g.

- 'I'm feeling anxious, therefore the situation must be dangerous.'
- 'I'm feeling embarrassed, therefore I must have made a fool of myself.'
- 'Unwanted thoughts make me feel anxious, therefore they must be dangerous.'

Your emotional reaction may have resulted from thoughts not reflecting the reality of the situation or experience; therefore basing your conclusion on your feelings only, leads you to a biased conclusion.

Negative prediction (or 'crystal ball gazing'): accepting your future predictions as fact, e.g.

- 'My OCD will never improve.'
- 'Treatment won't work, so what's the point of trying?'

The future is rarely 100% certain. Rather take action to help positive predictions come true!

Personalization: arbitrarily concluding that an event applies to you personally or 'taking things too personally', e.g.

- After your boss didn't smile when he walked past you: 'He's upset with me.'

Continued

You unreasonably exclude all other possible explanations for an event (e.g. maybe your boss is just having a bad day).

Mind reading: you assume that you know what others think, e.g.

- 'I got angry at him because I just knew what he was thinking!'

You may be wrong – best to check by asking or simply accepting that you can't be certain.

How CBT tackles emotional difficulties

In CBT, we learn to examine carefully our negative thoughts in situations. You may wonder whether this is all about changing negative to *positive* thinking? Sometimes yes, but not always. CBT is less about positive thinking than about *realistic* thinking. This is because we have to acknowledge that sometimes our negative perceptions of people, other situations or ourselves may turn out to be accurate. If we try to persuade ourselves to the contrary, we may end up becoming our own spin-doctor – unreasonably trying to force negatives into positives. At best, we may end up being over-optimistic or perhaps naïve. At worst, we may end up preventing ourselves from dealing with problems when this is called for.

How CBT makes sense of OCD

The framework I will be using is a variation of CBT theories of OCD, called the 'inference-based approach' (IBA), which was developed, by Professor Kieron O'Connor, Dr Frederick Aardema and Dr Marie-Claude Pélissier, in Montreal, Canada.

As previously discussed, the definitive symptoms of OCD are obsessions and rituals. But what is their relationship? On

the whole, we know that obsessions *cause* anxiety or discomfort. In turn, ritualizing is then used to *reduce* the anxiety or discomfort caused by the obsession or to *avoid* the anxiety or discomfort that would result if the obsession were left unchecked. Therefore ritualizing inevitably represents a way of trying to reduce the unpleasant feelings stirred up by the obsession.

You may ask why the obsession causes us to feel anxious or uncomfortable, and what causes the obsession in the first place? To answer this question we have to think carefully about the nature of obsessions. They would almost always involve uncertainty about things being awry in one way or another – in that sense representing a doubt about things not being OK.

This obsessional doubt is where the OCD ball starts rolling; for example, 'the door looks locked … but perhaps …', or 'the object looks clean … but maybe …' or 'I know I don't need to walk through the door a second time ... but just possibly …' You may counter that when you experience an obsession, you're not simply uncertain about things not being OK, you're *certain* they're not. However, this only means that the doubt is so strong as almost to represent a sense of being certain, but in essence it still remains a doubt.

When you consider the possible consequences *if this doubt were true*, and you didn't set things right in some way, that usually represents a dangerous or unpleasant situation. For example, 'If the door is unlocked, my house could be burgled', or 'if the object is contaminated with germs, I could infect my child', or 'if I don't walk through the door a second time, something bad will happen'. It therefore makes sense to try and remedy the situation by acting on the doubt to make sure that the feared consequences won't occur. This can be achieved in a number of ways:

- performing a ritual to reassure yourself (e.g. checking the

door a set number of times, despite knowing it is locked after the first check);
- asking someone else for reassurance (e.g. asking your partner if the door is locked after you have checked it yourself);
- avoiding the situation in future altogether (e.g. asking your partner to always lock the door).

To summarize, an obsessive thought always represents a doubt about things potentially not being OK (more guidance on identifying the doubt is provided in Chapter 5). If the doubt were true, and you didn't do anything to set things right, the consequences would be dangerous or unpleasant. Performing a ritual or asking someone else for reassurance represents an attempt to get certainty about things being OK. Avoidance of situations which trigger obsessive doubts is an attempt to sidestep the problem altogether. Unfortunately, these solutions do not deal with the problem of the obsessive doubts in any conclusive way and frequently only lead to more doubt. We will soon consider why this is the case. Figure 2 illustrates the relationship between the various components of your OCD (adapted from O'Connor et al., 2005).

How can CBT help my OCD?

The first part of Chapter 2 gave you an idea of the relationship between the obsessional doubt, what the doubt means to you, your emotional reaction to the doubt, and the strategies that you use to make the situation safe or reduce the unpleasant feelings caused by the doubt. Next we'll consider how to use this knowledge to tackle your OCD. First, we'll look at strategies that maintain your OCD and make it worse, and then we'll consider helpful alternatives.

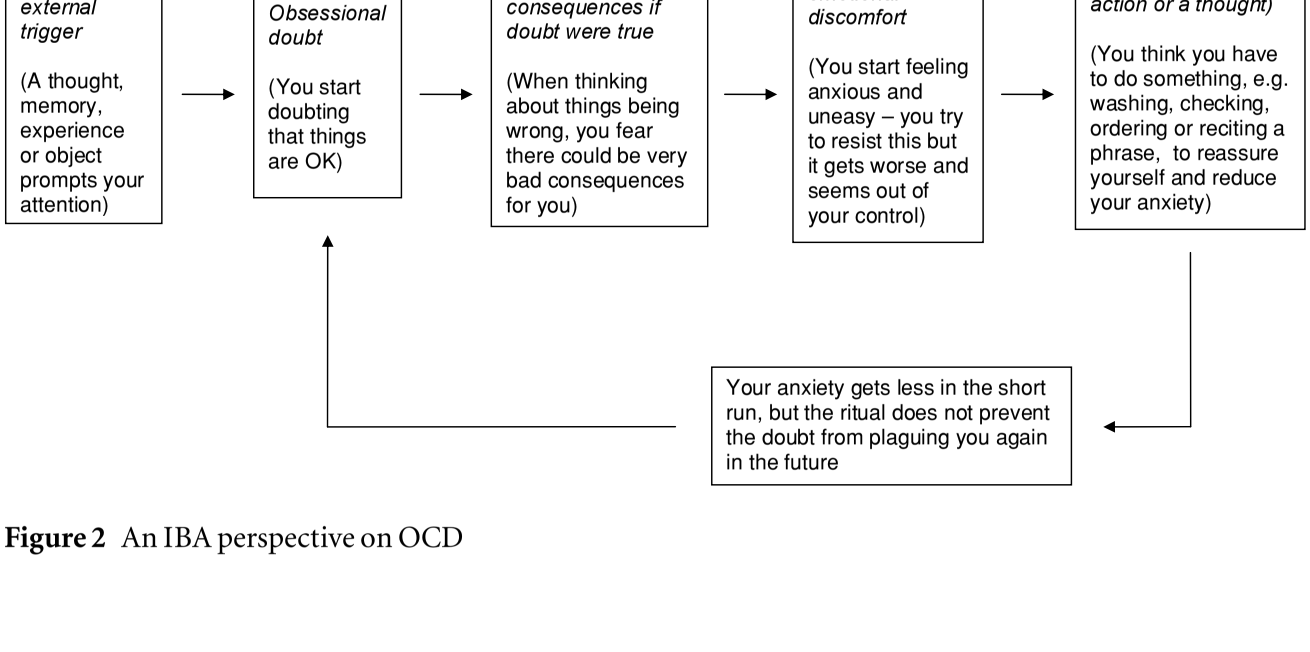

Figure 2 An IBA perspective on OCD

What doesn't help?

> Nothing fixes a thing so intensely in the memory as the wish to forget it.
>
> Montaigne

The following ways of responding to OCD have been found in research to be particularly unhelpful. They may appear to be helping your OCD, but in fact, they don't. They maintain the condition and make it worse.

Trying to suppress the obsessional doubt

It makes perfect sense to want to get rid of scary or unpleasant thoughts. However, this is more difficult than it seems. For example, try the following thought experiment: imagine finding a green fluorescent hamster with purple luminous eyes outside your house. Spend 30 seconds imagining exactly what he may look like. Do you have a clear image in your mind? Now – try *not* to think of the hamster for 60 seconds.

Did images of the hamster keep on popping into your mind despite your best attempts at suppressing it? People frequently experience this difficulty with thought suppression, and this may also apply particularly to the times when you try to push obsessions out of your mind. This is because obsessions, as we discussed above, cause anxiety and other negative feelings, and our brains are programmed to pay attention promptly to what we fear or to what puts our well-being at risk (ever tried to ignore a tiger while you were walking through the jungle?). This process sometimes becomes activated even before we are *consciously* aware that we are in danger. (In other situations it may protect us from danger and help us to survive, but as you will see, this is not relevant in OCD situations.) Therefore trying to push obsessions out of your mind by earmarking them *not to be attended to*, is a bit like switching the radar on and trying to ignore what it is bleeping back at you.

Ritualizing or reassurance-seeking

True, there is benefit to these strategies – you feel a bit better after you've performed your ritual or someone has reassured you, but this is usually only a temporary relief. Come the next situation where you experience the obsessional doubt, you have to repeat the rituals or find someone or something else to reassure you. The quest for peace and certainty by ritualizing is a gruelling journey, never completed.

OCD also has a nasty way of demanding more and more from you. Give it a finger and it takes the hand. As you give in to more ritualizing, you find yourself slowly slipping into a murky swamp where safety, contentedness and certainty seem to be ever further out of your reach.

Avoidance

It is understandable that you may be tempted to sidestep situations or objects that activate obsessions. The reasoning goes like this: no triggers – no obsessions – no problem. Unfortunately, this is a bit like the story where the patient complains to the doctor: 'My leg hurts when I walk,' and the doctor responds: 'OK, then don't walk'! By sidestepping situations that elicit obsessional thoughts, you may well avoid the unpleasantness of being harassed by them and having to perform time-consuming and frustrating rituals. However, this usually imposes limitations on your life and restricts your freedom and the choices you have.

But what if you don't really miss the activities that you've given up? Nevertheless, remember that there's always a risk that the OCD bully will start demanding *more* ritualizing and *more* avoidance, which may eventually add up to having a significant negative impact on your life. Also consider that avoidance tends to increase your reliance on other people for taking care of the activities you want to avoid. It reduces

the flexibility you need when unforeseen events require you to perform activities which the OCD has put out of your range.

What helps?

We've established that thought suppression, doing a ritual to reassure yourself, seeking reassurance from others, and avoidance, help to keep OCD in business. Apparent relief is offered in the short run, but this 'advantage' is offset by the considerable long-term drawbacks, which allow the condition to become more entrenched. If these strategies work against us, what can we do to find a more durable long-term solution? CBT researchers came up with the following answers:

Address obstacles standing in the way of confronting your OCD, such as depression and low motivation

As we have seen before, low mood can sometimes trigger the onset of OCD or cause an exacerbation of existing symptoms. Various background influences may contribute to a tendency to feeling low, such as your attitude to life, the quality of your relationships, stress and an unhealthy lifestyle. Alternatively, the constant pestering by OCD symptoms and the limitations they impose may cause you to feel depressed and demoralized. Whichever way low mood develops, it tends to be associated with symptoms such as tiredness, sleeping difficulties, feeling disheartened and a sense of the future looking bleak. This leaves you in poor shape to tackle a formidable project such as dealing with your OCD, which can seem an inextricable part of your life. We will address these issues in Chapter 4.

Examine and change those thinking processes that feed into the obsessional doubt

You may point out that the obsessional thought simply pops into your mind – there is no 'reasoning' or 'thinking' behind

it. This may seem to be the case, particularly if you've had the doubt in many situations, in which case it can start seeming automatic. However, if you examine the obsessional doubt carefully – rather than trying to suppress it, which we have seen is not helpful – it will become apparent that the doubt is always a *conclusion* about a state of affairs in the world. As with any conclusion we reach about things, there is always a chain of thought or reasoning leading to this conclusion, or an argument backing it up. For example, one part of the argument feeding into the doubt 'the iron may still be switched on' may be the following: 'I know that I checked a few times, but maybe I can't trust what I saw.'

Let's call this argument the '*OCD story*'. And it is the OCD story that gets you into trouble because it does not help you to resolve your doubt in the usual way, but actually only leads to more doubt. In Chapter 5 we will consider ways in which the OCD pulls the wool over your eyes by using the OCD story, which may seem deceptively logical and reasonable, but doesn't stand up to examination.

Examine and change your thinking about the negative consequences if the obsessional doubt were true

As illustrated in the examples above, the obsessive doubt holds a certain meaning for us. We have ideas as to which consequences are likely to follow if the doubt were true and we left the situation unchecked. In OCD, the consequences are usually pretty bad or scary and we may consider that we will be held solely responsible for such consequences. For example, if you left the iron switched on, your house may burn down causing you to be ruined financially, leaving you and your family destitute – all your fault.

Because the consequences are so negative – you may see a negative drama playing out vividly in your mind – it is very difficult to ignore the doubt. And so it is much easier to opt for playing safe by avoiding the situation altogether, or

reassuring yourself by using a ritual or seeking reassurance from someone else.

However, if you were to examine your thoughts about the consequences if the doubt were true, you may discover that they are not quite as bad as you feared. For example, if your house burnt down your home insurance will pay out and you and your family will be very unlikely to become destitute.

This alternative viewpoint may allow you to be less upset or anxious when you have the doubt. Consequently, if you are less upset, it may well be easier not to feel that you have to do the rituals, or the urge may be less intense because you see less point in the rituals. Similarly, you may see less reason for avoiding situations that elicit obsessional doubts. Therefore there may be some scope for improving your OCD by examining whether the consequences would actually be quite as bad as you fear they may be if your doubt were true and you left the situation unchecked. We will be looking at this in detail in Chapter 6.

Nevertheless, we have to recognize that there are some circumstances in which your thinking about what may happen if the doubt were true, may be quite realistic – that is, those consequences may well be very unpleasant. In that case, this point is not as useful in working on your OCD, and it would be helpful to concentrate your efforts working in the areas listed previously as well as the one below.

Eliminate ritualizing, reassurance-seeking and avoidance

We have previously considered that performing a ritual or using other forms of reassurance-seeking in response to an obsession only helps briefly and then you are back to square one. A temporary reduction in anxiety or discomfort is achieved, but the anxiety is reignited the next time the obsession is experienced, and like a nagging mosquito, the obsession always returns! *Ritualizing is never a long-term solution.*

Why is this the case? The answer is to be found in considering the reasons for why you need the ritual in the first place. This may well be because you want to reduce your anxiety. But what is the origin of the anxiety?

The anxiety stems from the scary or upsetting consequences if the obsessional doubt were true. And you take these consequences seriously because you may think of the obsessional doubt ('something is not OK') as being *real or credible* – and so it all goes back to the doubt. Ritualizing may over time even reinforce a sense of the doubt being real and credible, as a consequence of repeatedly addressing the problem of the doubt as if it were in fact a normal doubt. For these reasons, doing rituals maintains your OCD.

The pitfalls of simple avoidance have been discussed previously. Similarly to ritualizing, consider that it only makes sense to avoid a situation that triggers obsessional doubts, if you consider such doubts to be valid. Ongoing avoidance restricts your freedom and also reinforces the doubt because you're acting as if the doubt were valid. Ritualizing, reassurance-seeking and avoidance will be addressed in Chapters 7 and 8.

Biological explanations and treatments of OCD

As discussed previously, certain ways of thinking set us up for developing OCD, and maintain the condition once it has started. These ways of thinking will be considered in more detail in Chapters 5 and 6. However, researchers have also uncovered evidence that biological factors may contribute to a vulnerability for getting OCD. When these combine with psychological factors, it may become very likely that you will develop OCD.

So which biological factors are involved? Studies using brain scanning technology suggest that people with OCD have patterns of brain activity that differ from those without a

mental health condition, and from those suffering from different conditions to OCD.

More specifically, increased brain activity has been detected in regions of the brain, including the prefrontal cortex (at the front of the brain) and the striatum (in the middle of the brain). A researcher, Dr Jeffrey Schwartz, and his colleagues at the University of California Los Angeles (UCLA) believe that the prefrontal cortex produces warning signals and it is up to the striatum to switch the signal off. However, in the case of OCD, this process doesn't function as it should and the person may continue to have a sense of something being wrong because the danger signals aren't being switched off in the usual way (Schwartz, 1998). However, a tricky problem with this and other biological findings in OCD is whether the observed differences between people with and without OCD are a cause or a consequence of OCD.

Another theory holds that there may be a chemical imbalance in OCD. Most of the attention has been focused on a brain chemical called serotonin, given that drugs that change serotonin levels have been shown to be helpful in OCD (see below). Serotonin is one of a group of substances called neurotransmitters, which are substances that help with the transmission of nerve impulses in the brain.

The class of antidepressant drug that increases the effects of serotonin in the brain is called the selective serotonin reuptake inhibitors, or SSRIs. These drugs have been shown to reduce OCD symptoms in about 40–60% of people who completed a course of treatment. Examples of SSRIs include sertraline, paroxetine, fluoxetine, fluvoxamine, citalopram and escitalopram. (These are the generic names of the drugs – they are marketed under different brand names or proprietary names in different countries.)

The recently published National Institute for Clinical Excellence (NICE) guidelines in the UK, recommend that

SSRIs should be the medication tried first for OCD. Sometimes when treatment with an SSRI has not been helpful, treatment with clomipramine is considered. Clomipramine is a member of a class of drug called the tricyclic antidepressants, and it also affects the level of serotonin. Usually the tricyclic antidepressants are thought not to be helpful in OCD, but clomipramine is the exception. Dosing at the higher end of the dose range (i.e. the range within which a drug may safely be prescribed) is often required.

In the case of very severe OCD which does not benefit from treatment with SSRIs or clomipramine, an antipsychotic medication may be combined with a SSRI or clomipramine. Examples of antipsychotic medications used include quetiapine and risperidone.

Many people considering drug treatments for OCD are worried about becoming dependent on the medications. In this respect it may be reassuring that none of the treatments listed above are thought to be significantly dependency-forming (or habit-forming), so you will not develop a craving for the drug. However, drawbacks you need to consider include the following:

- Improvement in OCD symptoms in response to antidepressant medications is commonly delayed for up to 12 weeks after starting treatment. Mood symptoms tend to respond sooner, but this may also require a number of weeks.
- There is a moderate risk that OCD symptoms get worse again if you discontinue treatment with the antidepressant medication. Some studies suggest that more people relapse after discontinuing treatment with medication, and they relapse sooner, than after discontinuing behaviour (a forerunner of CBT with significant overlap) therapy.
- There is a range of potential side effects associated with medication; for example, in the case of the SSRIs you may

experience nausea, insomnia, sexual dysfunction or other symptoms, although most people tolerate the drugs with little or no difficulty. Initial side effects may wear off over time as your body adjusts to the medication. You may experience withdrawal symptoms after stopping the drug or when missing a dose; to minimize the risk of this happening your medical practitioner may advise you to reduce the dosage gradually. Always inform your medical practitioner if you experience unusual or persevering side effects or withdrawal effects.

But how do the biological theories and treatments square up with the psychological theories and treatments considered previously? You may well argue that both can't be true! The fact is that all of the theories we have considered, both psychological and biological, may provide us with accurate descriptions of a complex condition. For example, some research studies looked at the effects of CBT and drug therapy, respectively, on brain activity. Recall that abnormal patterns of brain activity have been found in OCD. Interestingly, successful treatment with *either form of treatment* led to some normalization of brain activity (e.g. Schwartz et al., 1996)! This shows us that different treatments can be beneficial, possibly by causing similar changes in the brain.

Which is more effective, treatment with antidepressants, behaviour therapy or CBT, or a combination of the two? At present the evidence points to behaviour therapy or CBT being equivalent to medication, but combination therapy may work better than either on its own. As said previously, there is a lower chance of symptoms recurring after finishing behaviour therapy or CBT, than after stopping medication.

Which is the treatment for me?

At this point you may well be pondering the question above – medication, CBT or both? Perhaps it may be informative to consider the NICE guidelines for the treatment of OCD that inform the National Health Service in the UK. They suggest the following: if your OCD causes only *mild* functional impairment (i.e. only little disruption to your daily life), brief CBT is the approach of choice. If there is *moderate* functional impairment, a longer course of CBT or a course of medication should be used, and if impairment is *severe*, a combination of treatments should be used.

Whichever you decide, CBT always has the potential to be useful. Medication may be helpful if: you do not make as much progress with the psychological approach as you would like to; if your OCD is severe; or if feeling depressed stands in the way of using CBT effectively (although CBT strategies can also be useful for dealing with low mood). You may consider the following advantages and disadvantages of CBT and medication when deciding which treatments to use (table 2).

Table 2 Advantages and disadvantages of cognitive-behavioural therapy (CBT) and medication

	Advantages	Disadvantages
CBT	Effective Small risk of relapse after end of treatment Also useful for treating low mood	Requires ongoing time and effort Time-consuming Expert help not always available
Medication	Effective Little time or effort required Also useful for treating low mood	Potential side effects or withdrawal symptoms Moderate risk of relapse after end of treatment

A cognitive track or behavioural track programme for overcoming your OCD

Chapters 1 and 2 provided a general introduction to OCD and introduced you to CBT. Chapter 3 will introduce you to eight people with OCD, whose progress we will be following in the rest of the book. In Chapter 4 we will consider ways of improving low mood and low motivation standing in the way of progress, and how to use self-help effectively.

Next, there are two treatment options to choose from: cognitive track treatment (Chapters 5–7); *or* behavioural track treatment (Chapter 8). Cognitive track treatment employs interventions aimed at changing the unhelpful *thinking* tendencies underlying OCD; in Chapter 5 the focus is on the argument supporting the obsessional doubt; Chapter 6 examines your thinking about what would happen if the doubt were true and you didn't do the ritual; and Chapter 7 concludes the work on the OCD thinking by helping you to reduce levels of ritualizing or reassurance-seeking in response to obsessions, or avoidance of situations that trigger obsessions.

The behavioural track option in Chapter 8 focuses on your rituals or avoidance more directly (i.e. on changing your *behaviour*). It uses exposure and response prevention therapy (ERP), a powerful treatment approach targeting ritualizing, reassurance-seeking and avoidance *directly*.

Moving on from direct treatment, Chapter 9 considers how to address your OCD in a holistic way, by also looking at the role of background factors, such as your attitude to life, your relationships and your lifestyle. Lastly, Chapter 10 focuses on how to prevent relapse and stay well. Figure 3 describes the focus areas of the various chapters in this book.

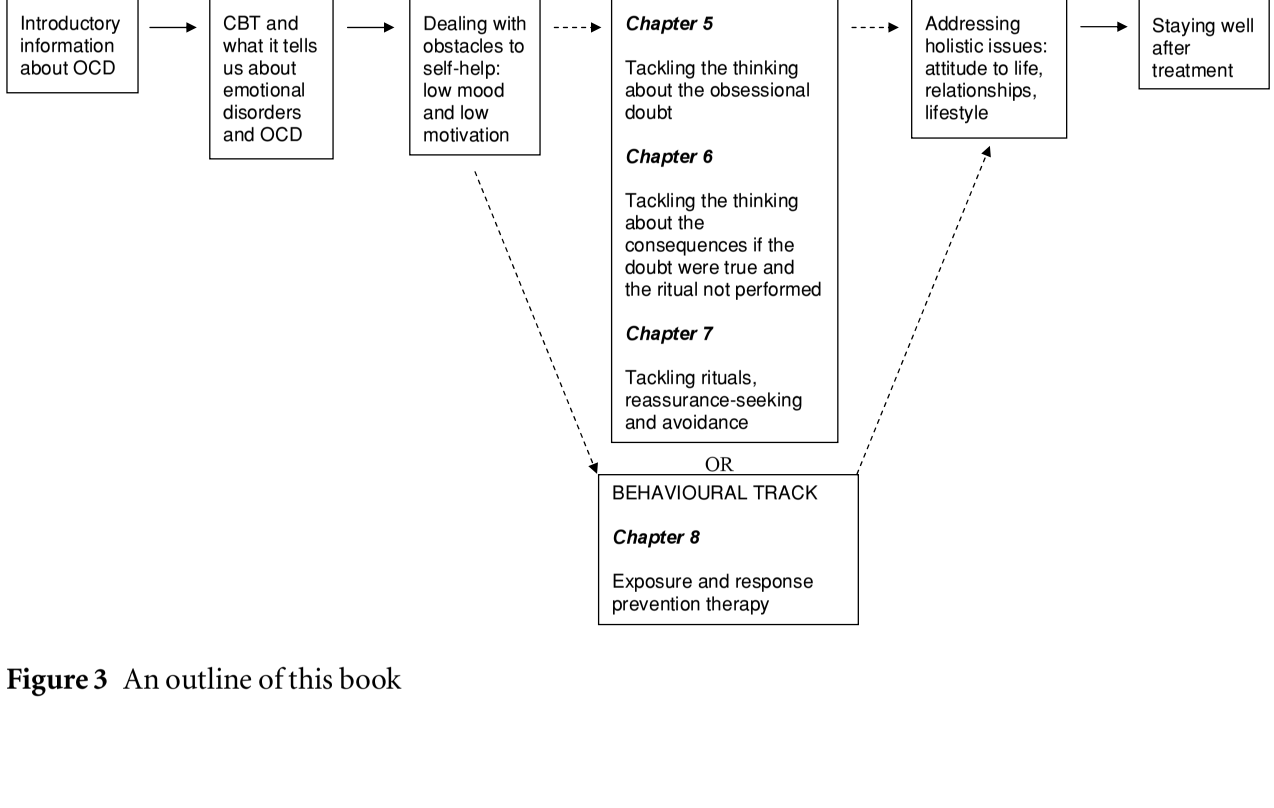

Figure 3 An outline of this book

Which programme is right for me?

As you will see in the following chapters, the cognitive track treatment option aims to reduce your anxiety by changing the thinking feeding into your obsessional fears *before* shifting the focus to the reduction of ritualizing and avoidance. The main approach in the behavioural track option is exposure and response prevention therapy (ERP), a forerunner to CBT approaches. ERP is a very direct and powerful therapy for OCD. It aims to reduce your anxiety by assisting you to systematically expose yourself to situations that trigger obsessions, and then reduce and ultimately eliminate performing rituals. People undergoing ERP find that their thinking about the situation changes and their anxiety gets less *after* they change their behaviours (i.e. face the situation and not perform rituals).

But which is the right option for you? To help you answer this, consider the situation in which your obsessions and rituals cause the most disruption in your life, or the situation in which your obsessions are the most intense. Ask yourself: what is my level of conviction on a 0–100% scale that something terrible will indeed happen in this situation *if I didn't perform a ritual or didn't avoid the situation*? If your belief level is *above 50%*, I recommend the cognitive track. However, if your belief level is *below and up to 50%*, the behavioural track may be appropriate for you.

Another consideration relates to the nature of your emotional experience in situations that trigger your obsessional fears. If the emotion is predominantly anxiety, the behavioural track may be effective; however, if your emotions are more complex, for example, also including guilt or shame, the cognitive track may be particularly useful.

An advantage of the cognitive track is that, in my opinion, it enables you to develop a better understanding of your OCD

prior to reducing the ritual, and therefore allows a more insightful experience allowing you to stop the rituals in an easier way. Advantages of the behavioural track are that it is very powerful, generally less time-consuming and relatively more simple and straightforward than the cognitive track; however, anxiety levels and discomfort experienced during this programme tend to be higher.

My experience in my clinical practice is that the majority of people find that working on their OCD thinking benefits them through helping them to discover that their obsessional fears are unfounded or exaggerated and thereby making it easier not to ritualize or avoid. However, the two approaches are not mutually exclusive and the cognitive track also benefits from methods used in the behavioural track; for example, in Chapter 7 methods similar to ERP (in Chapter 8) are used to consolidate the work on OCD thinking described in Chapters 5 and 6. Ultimately you may prefer first to read the relevant chapters before making up your mind about which approach is the suitable one for you.

Key points

- Our thoughts in a situation influence our feelings and what we decide to do in response to the situation.
- Cognitive-behavioural therapy (CBT) aims to help you develop strategies for changing your thinking and behaviour in situations, to allow you to cope better.
- When applying the CBT model to OCD, we find that an obsessional doubt causes anxiety or other negative feelings. This is because you worry about what may happen if the doubt were true.
- You then do a ritual to set things straight or reduce the anxiety, or you ask someone else for reassurance, or you avoid the situation altogether.

- Trying to suppress the obsession, doing rituals or avoiding the situation maintains your OCD.
- Re-thinking the argument that supports the doubt and what you fear may happen if the doubt were true, and reducing ritualizing and avoidance, may help to improve your OCD.