Fiona Kennedy describes the corrosive effects of obsessive compulsive disorder on people's lives and how to work with it

What if I...?

Paulo is a successful, charming businessman, working in the fashion industry. He has a powerful ability to visualise, which he uses in his work. Paulo is dyslexic and felt a failure at school; he disappointed his teachers and parents by failing to follow in his brother's academic footsteps. He became the joker, always up to mischief, but inside he was highly anxious.

His father died when he was seven and Paulo was brought up with a terrifying, physically abusive stepfather. At puberty, he worried about getting erections by accident in public. In adulthood, at work, he would excessively check his output for errors. When he married and started a family, he began to panic about harm coming to the children. He avoided travelling long distances and going on holiday through fear that he would have an asthma attack and cause an accident. His sleep was disturbed by 'what if' thoughts, which he dealt with by making complex plans to prevent harm coming to himself or those he loved.

Then a colleague was arrested for grooming a 13-year-old. Paulo was appalled. He thought, 'I was his friend - perhaps I'm a paedophile too.' Checking back over past relationships, he remembered being in a relationship with a 15-year-old when he was 16, confirming his belief. He became withdrawn, sleepless and depressed, and began avoiding going out in case he saw a child, and tried not to watch any media with any sexual content.

What is OCD?

Obsessions are defined in DSM-5 and ICD-10, the diagnostic manuals for mental ill health, as recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress. The person reacts against the thoughts and tries to ignore, suppress or 'neutralise' them with other thoughts or actions. The thoughts frequently involve being responsible for harm to others and an urge to do something to prevent that harm. They may also involve fear of harm to the self, such as being contaminated by germs and contaminating others. Many obsessional thoughts begin with 'What if?'. Sexual themes are common - for example, someone might obsessively fantasise about their friend's husband when with their own partner. Religious themes are also common. My Catholic grandmother believed that if we recited the '30 Days Prayer' each day without

fail for 30 days, we'd achieve our life's desires. As a girl, I spent endless evenings plodding through it, with Nana in the other bed doing the same. Neither of us ever managed to complete the 30 days. Little did I realise at the time, but this was a classic example of obsessive compulsive disorder (OCD).

Intrusive thoughts and images are often negative, but positive thoughts can be distressing too. 'Pride comes before a fall', for example, expresses the notion that, if you are too pleased with yourself or your own performance, or take something for granted, things will go badly wrong.

Obsessions are always accompanied by compulsions. In the past it was thought that there was a subtype of people who did not experience compulsions (so-called 'pure' obsessional thinkers). However, once covert rituals (eg thinking a 'good' thought) and reassurance-seeking were recognised as compulsions, studies found that 100% of people with obsessions have compulsions.[1,2] Compulsions are repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession or according to rigid rules. The actions are aimed at reducing distress or preventing some dreaded event or situation, but are either not connected in a realistic way with the event or are clearly excessive. Examples include cleaning, hand washing, checking (plugs, doors, locks or one's appearance). They may involve rituals such as arranging things, doing things in a certain order or counting, touching, rubbing or tapping, blinking or even staring. One client, who had intrusive thoughts about cutting his beloved father's throat, felt the compulsion to 'neutralise' these thoughts by loudly shouting 'F*** off!' People with Asperger's and autism are particularly prone to OCD, possibly because they live with high baseline anxiety.

> 'People with lifetime OCD report spending as many as six hours a day on obsessions and four-and-a-half hours a day on compulsions'

People with lifetime OCD report spending as many as six hours a day on obsessions and four-and-a-half hours a day on compulsions. This severely affects home life, social functioning, academic achievement, employment and use of health care. Between 30-60% of people with OCD are unemployed, and 99% have another disorder - most frequently, mood disorders, especially severe depression, and anxiety disorders, especially social phobia, specific phobia and panic.[3]

OCD is rare - only two to three per cent of us will experience it, but 13-28% of us experience some OCD symptoms. For one in four men with OCD, it starts before the age of 10. For women, onset tends to be in the teens or early adulthood and there is an increased risk of developing OCD after giving birth. Tics, depression and substance use in childhood and early adolescence are risk indicators for OCD, as is having a close relative with OCD.[3]

What works with OCD?

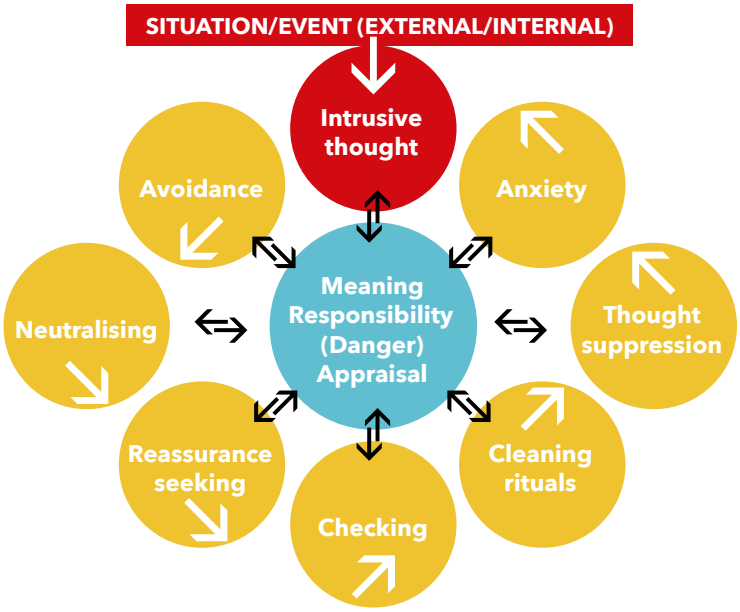
NICE recommends cognitive behavioural therapy (CBT) for OCD. It also recommends SSRI antidepressants, in combination with CBT when OCD and depression are present together.[4] There is a growing evidence base for acceptance and commitment therapy (ACT) for OCD.[5] These therapies change the way the client relates to their thoughts and feelings. CBT produces new perspectives, changing the meaning a person gives to their thoughts. ACT focuses on 'defusion' and mindfulness practices, such as noticing one's thoughts without engaging with them, as well as clarifying values, as outlined below.

In assessment, as well as the clinical interview, asking the client to keep a diary of thoughts/images/urges, the meaning ascribed to them and the compulsions they perform can give a good baseline, as well as providing material to target. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS)[6,7] identifies target symptoms and level of insight. The Obsessive Beliefs Questionnaire (OBQ-44)[8] helps identify beliefs driving the cycle.

The most commonly used formulation of OCD from a CBT perspective is Salkovskis' 'Vicious Flower' (see left).[9]

Applying this to Paulo, he appraised as true his thoughts about being a paedophile simply because he had them. Having the thoughts meant he was a bad person and might harm a child, and that he was responsible for preventing this happening. He sought reassurance and checked his memories for any signs of paedophile behaviour (compulsions). The harder he tried to remember, the more confused he got, ▶

FIGURE 1: SALKOVSKIS' 'VICIOUS FLOWER'[9]



until he felt he could not trust his memory and might have forgotten important incidents. He tried not to think about being a paedophile, and failed, making him feel out of control. He also used avoidance (making sure he was never alone with children).

Understanding obsessions

Intrusive thoughts are often negative and obviously upsetting for the client but they can also be neutral or even positive. It is the catastrophic appraisal of the thought that can lead to fear, guilt, disgust and shame. OCD involves 'overthinking': fruitless attempts to solve the problem. Anxiety levels rise, thinking becomes more black and white and extreme, and clarity is lost. Occasional 'success' keeps the process going. Thought suppression results in more negative appraisals of the thought, and also a feeling of failure to control thoughts.

Avoidance of situations, conversations or other input that might trigger obsessional thoughts can lead to constriction of the person's life and reduction of joy and pleasure and pave the way for depression. As well as the risk factors mentioned above, negative feelings about the self (self-schemas or core beliefs) create vulnerability to developing OCD. An exaggerated sense of responsibility may be learned in childhood by being held responsible by others, such as teachers or parents. A core belief such as 'I am a bad person' may create an underlying assumption that 'I am responsible', which in turn leads to negative automatic obsessional thoughts such as 'It's my fault'.

Understanding compulsions

It is generally accepted that the purpose of performing compulsive behaviours is to reduce distress. The distressing thought creates anxiety and the person does something to decrease the anxiety, if only for a short time ('negative reinforcement'). Positive reinforcement can be present - for example, when a person gets pleasure from a sense of control. These 'short-term gains' keep the behaviour going. But compulsions cause long-term pain, such as shame, embarrassment, fatigue and missing out on life.

Recent work[10-12] has shown how repeating actions leads to changes in the way information is processed. Just glancing at a clock, we know the time. But if we stare at it for several minutes, we will be less sure. The more repetitions, the less certain we become of exactly what we've done and whether we've done it properly. As our certainty decreases, the need to repeat increases.[13] We also switch from perceptual to conceptual processing, thinking excessively as we repeat. 'Parsing' happens with repetition - we break down actions into smaller and smaller parts. For example, instead of just washing my hands, I must wash the palms, then the backs, then the thumbs, fingers, under the nails, between the fingers etc. Now it becomes hard to remember whether I have done all of it or not, which means I have to start the sequence again, to feel sure.

Christine Purdon and her team at the University of Waterloo, Canada, recently studied the detail of what people are up to when they are carrying out compulsions.[14] Participants were people who washed their hands excessively. She discovered that people stopped their compulsions voluntarily about 53% of the time. The rest were stopped involuntarily because the person was interrupted or had to go out or go to work etc. Paul Salkovskis has coined the term 'stop rules' to describe the conditions that allow people to stop voluntarily.[15] Like him, Purdon found that there had to be a 'felt sense' of satisfaction - a sense that the washing had prevented harm. Without this, the person was not able to stop. There were no objective criteria such as the number of times or length of time that the actions were repeated.

The fact that a compulsion is a subjective feeling makes it tricky to limit the behaviour in any objective way. If we ask the client to limit the number of repetitions, for example, they will not get the 'felt sense' signalling 'stop'. Without the felt sense, the client's confidence in their memory goes down. Purdon also found that compulsive behaviour needs a trigger - it does not just randomly occur. So, for example, touching something that might be contaminated is often a trigger for washing.

'The more repetitions, the less certain we become of exactly what we've done and whether we've done it properly'

Treating obsessions and compulsions

Values work

The treatment of OCD historically has involved exposure (eg touching a toilet seat) and response prevention (eg not washing the hands afterwards). Though successful 70% of the time for willing clients, there is an almost 50% refusal and drop-out rate. We need a very strong reason to willingly experience the horrible feelings that exposure work brings. If I asked you to walk over some hot coals, you would say no. If I asked you to walk over hot coals to save a loved one's life, you probably would.

Values work helps the client get clear on what kind of person they want to be and what kind of life they want to lead, ideally. So, values are the reason for reducing compulsions. Paulo, for example, wants to be a fun and loving father; he wants to go swimming with his son, but his paedophile obsessions get in the way. The 'two pieces of paper' exercise from ACT involves writing your values on one piece of paper and appraisals of your obsessional thoughts on another. The values paper might say 'Be a fun dad', 'Be a supportive and available partner'. The thoughts paper might say 'This thought about being a paedophile means I might be one', 'I need to protect all children from my terrible urges'. The client holds the pieces of paper, one in each hand. When we hold the thoughts paper closer to our face we can see only thoughts. When we hold the values paper near to our face, we see our long-term life goals. The thoughts are still there but farther away from us; they are not our focus. The ability to focus on our values can be learned with practice. This can help us tolerate discomfort on our journey towards a life we value.

Working with obsessions

We have two options when working with obsessional thoughts and feelings: working with the appraisal of the thoughts and working with the thought processes.

It's important to validate the client's distress and normalise their experience. Psychoeducation is useful - for example, sharing facts. Purdon and Clark,[16] found that as many as 22% of men and 11% of

women had had thoughts about choking a family member. Learning that no one has complete control over their thoughts and that it is impossible to avoid mistakes are also important. The 'junk email' metaphor is useful too: if you received an offer to put £10,000,000 into your bank account, you would probably delete it. But instead of deleting thoughts, we appraise or interpret them as signals of threat that indicate that something needs to be done now.

The problem in OCD is not fear of something terrible happening to you or a loved one; it is the belief that the thoughts are indications that harm will occur, that immediate action is required, no matter how minute the probability of harm, and that it is morally imperative to perform the compulsion and achieve certainty. The therapist aims to help the client see these thoughts as naughty puppies in the backyard of their mind – out of control and in need of training. We want to put the person back in charge, not by getting rid of the puppies but by stopping them taking over the whole of our life.

We can use Socratic questioning to curiously explore appraisals of the thoughts: 'How did you learn that this thought means X will happen?'; 'What would someone who disagreed say?'; 'You seem to be assuming that if you think X you need to do Y...' We can use Theory A vs Theory B. Theory A says: 'This thought says I could be HIV positive. I need to be absolutely certain I'm not. It would be irresponsible not to get repeatedly tested.' Theory B says: 'This is just a thought. I can accept the tiny risk I might be HIV positive just as I accept the risks of driving.' We can set up behavioural experiments to test out Theory A and Theory B. 'Helicoptering' is a great technique – we can teach clients to stop, mentally hover above the situation, look down at what's happening, check out their values and decide from there how to proceed.

With intrusive thinking processes, we can show clients how overthinking increases anxiety and doubt and befuddles us, even though it produces occasional relief. We can teach alternatives to engaging with the content of the thoughts. Mindfulness skills can, with practice, allow us to leave horrible thoughts and feelings floating on the surface of our awareness. We can 'drop an anchor' onto our breath, or onto an activity that pursues our values. 'Defusion' skills from ACT, such as singing intrusive thoughts in the shower to a popular tune, can help you gain perspective and become aware that they are just thoughts. Teaching clients to tolerate uncertainty and challenge the idea that perfection is always required are other important strategies.

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About the author

Fiona spent 25 years in the NHS providing and managing psychology services, teaching and carrying out research. She now owns GreenWood Mentors Ltd, which provides therapy, clinical training and supervision. She is co-editor of *Cognitive Behavioural Approaches to the Understanding and Treatment of Dissociation* (Routledge, 2013) and co-author of *Get Your Life Back: The Most Effective Therapies for a Better You* (Robinson, 2017). She volunteers in India, designing and consulting on mentoring programmes for disadvantaged children and young people. **drkennedy@greenwoodmentors.com**

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Working with compulsions

Staying focused on values increases willingness to tolerate the horrible feelings that will come along if we resist the urge to carry out a compulsion. Perhaps you yourself have a mild compulsion, such as needing to turn the toilet roll so the paper hangs away from the wall? If you choose to resist the urge, the feeling of anxiety or disgust or distress will increase, and then decrease. Most clients are not aware that the decreasing bit will happen; they believe the feelings will just get worse. The metaphor of urge-surfing is useful: if we mindfully sit with an urge, say to scratch our nose, the urge will increase and then, within a minute or so, decrease. It's like being a surfer balancing on the surfboard until the wave subsides and comes gracefully to the beach.

Setting 'finishing criteria' for compulsions, such as 'I will stop washing my hands after two minutes', is a common intervention. But then the client does not have the 'felt sense', which is the usual signal to stop. Mindfulness practice allows clients to experience anxiety and self-doubt and learn they can be tolerated.

Behavioural experiments involve clients making predictions about what will happen if the compulsion is not carried out. Paulo might say: 'If I don't take my asthma inhaler in the car, I will have a panic attack, be unable to breathe and crash the car.' He could make alternative predictions: 'If I don't take my asthma inhaler but use my paced breathing skills and stay focused on my realistic thoughts, I will be fine,' or 'I may have a panic attack but I can still drive my car safely while that is happening.' After working on new skills and insights, Paulo could test out the predictions and see which ones best fit what happens when he drives the car.

Working with avoidance/escape

Avoiding triggers of intrusive thoughts and images, avoiding talking or thinking about the content of thoughts and attempting to neutralise behaviours all serve to strengthen OCD through negative reinforcement. 'Widening the window of tolerance' means expanding the client's range of exposure to challenging or triggering activities and situations. This can be done by practising mindful acceptance of urges to avoid, reducing advance planning and reducing reassurance-seeking. Graded exposure to feared situations allows the client to practise new coping skills.

Working with core beliefs/schemas

Core beliefs or schemas are beliefs about ourselves learned in childhood. Typical examples include: 'I am not good enough/a failure'; 'I am a bad person'; 'I am unlovable'; 'The world is a dangerous place'; 'Other people are unavailable.' These lead to underlying assumptions, such as 'I must prevent harm coming to others'; 'I must get everything right'; 'I could be responsible for bad things happening.' The downward arrow technique can help access core beliefs: 'What does it mean that you have these intrusive thoughts?' The client who is afraid she might drop the baby might say 'It means I can't be trusted'. 'And what does that mean?' 'It means I am a bad person'.

Once the core beliefs are clear, we can use the CBT thought-reviewing techniques ▶

RECOVERY COURSE

N The problems were **Named** – 'I am having thoughts/an image about being a paedophile and needing to check to make sure I'm not' – and acceptance shown.

A **Awareness** was built with validation of the client's thoughts, feelings (shame and self-disgust) and behaviours around the problem. We used formulations describing thought processes and compulsions in detail.

V Paulo was helped to clarify his **Values** about being a good father and having fun with his kids.

I We **Identified** the function of the problem – Paulo was trying to reduce his anxiety by seeking reassurance from his wife, by avoiding children, by checking back through his memory for times he may have behaved like a paedophile. All of these gave short-term gain and long-term pain. Paulo planned to use mindfulness skills and urge-surfing to resist these behaviours and tolerate the discomfort.

G Paulo set some **Goals** in line with his values: he wanted to go swimming with his son. He began with 'baby steps' towards this goal, such as driving his son to the pool and watching him have a lesson.

A Paulo was helped to **Accept** himself and counteract his core beliefs that he was not good enough. He made an image of 'little Paulo' and began to show compassion to this 'inner child'.

T Paulo was helped to **Tackle trauma** in his past by understanding the effects of being bullied at school and his violent stepdad on his belief in himself. He was taught to make powerful and competent images of himself handling these bullies.

E Paulo was helped to become aware of his **Emotions** and reduce their intensity. He used graded **Exposure** to gradually stay in situations that triggered his paedophile fears.

S Paulo was taught new **Skills**, including mindfulness, self-soothing, paced breathing and urge-surfing to help him move away from his obsession and towards his valued life.

described earlier. Compassion focused therapy (CFT) and schema therapy offer ways of inducing self-compassion, such as the two-chair technique. The client becomes their 'inner bully' in one chair and speaks to their 'self' in the other chair. It's often shocking how brutal the words and tone they use can be. The client then occupies the opposite chair and argues against the bully, ideally accessing some emotional response, but certainly daring to stand up to the bully and defend him or herself.

With Paulo, I used CBT+, an approach integrating CBT, ACT, CFT and DBT (dialectical behaviour therapy) that I have developed with my colleague David Pearson.[17] We take the client through a process for which the acronym is NAVIGATES, as illustrated in the box above.

Obsessional thoughts and the compulsions that go with them are very common; it is the distress they cause that we should treat. There are techniques that can provide the client with alternative ways of dealing with their distressing thoughts, feelings and urges. Values are important - they represent the reason why someone might be willing to tolerate increased discomfort in the short term in return for greater richness of and satisfaction with their life. Counsellors can be very helpful for people with OCD, provided they are familiar with what works and have some specialist training. ■

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