Coping with obsessions and compulsions

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Produced November 2010
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Part A – Understanding obsessions and compulsions

Introduction

I wonder how many people reading this have ever had ideas they have found weird, or done things knowing that they were silly? How many people have ever left the house and thought “Did I just lock the front door” and gone back to make sure? Or stood at a platform waiting for a train or tube and thought “What if I just jumped off?” How many people avoid the number 13, or walk round ladders rather than under them? Most people find that from time to time they have worrying thoughts which they cannot get out of their head, or that they carry out repetitive actions which are not necessary.

For most of us ideas like this come and go in our lives without troubling us too much, but when they become very exaggerated it may be that we are developing OCD, or Obessional Compulsive Disorder. Although these thoughts or actions may sometimes be quite strange, we should make it clear straight away that having OCD does not mean that you are going mad. OCD is an exaggeration of normal thoughts and actions which happen in nearly everyone. The line between ‘normal’ and ‘abnormal’ obsessions is often very vague. In general we say that someone has OCD if the problems have become so severe that they affect their relationships and quality of life.

This book focuses on what Obsessions and Compulsions are, and what keeps them going. It provides specific guidelines about what you can do to help decrease the anxiety that obsessions and compulsions cause, and reduce the impact that they have in your life.
What is Obsessional Compulsive Disorder (OCD)

Very roughly, an *obsession* is something - usually a thought - which makes you feel very anxious. Sometimes these thoughts are in the form of images or pictures in your mind rather than words; sometimes they are in the form of impulses or urges — a sudden feeling that you might go and do something, usually something awful. Obsessions usually come into our mind when we don’t want them, often out of the blue, and are usually very unpleasant.

The *compulsion* is the behaviour performed in order to ‘put right’ the obsession. *These ‘compulsions’ are designed to make you feel better, so you don’t have to worry anymore.* The person usually knows that the actions carried out are unnecessary and perhaps irrational, and this often becomes very frustrating. Compulsive behaviours are actions such as washing hands or checking the door many times, but sometimes these ‘actions’ can also be in your head, such as counting in sevens for seven minutes. The important thing is that people feel *compelled* to carry out the actions. Even if you know in your heart of hearts that you are being silly, you can’t resist doing it, just in case.

Is OCD common?

It was once thought that OCD was rare, but recently there seems to have been a growing awareness of it, perhaps by virtue of articles in magazines and TV programmes. As a result, people may be more willing to go to their Doctor to talk about their symptoms. At the moment we think that about 2-3%
of the population have OCD. This is less than the number of people who have problems with anxiety or depression, but it is still pretty high.

**Different types of OCD**

OCD can take many different forms, but most commonly consists of repetitive **thoughts** and/or **actions**. Although everyone with OCD has some things in common, there are distinct subtypes. Common ones are described below.

**Cleaning**

One of the most common forms of OCD is the fear that you may come into contact with contamination of some sort, and as a result may become ill or die, or pass on the contamination and risk of illness. As a result, people spend an excessive amount of time washing themselves and cleaning objects. Some common things that people are afraid may be contaminated are food, public toilets, blood – anything where ‘germs’ might linger. People may also go to great lengths to avoid contact with things that might be contaminated. It is not uncommon, for instance, for people to throw away food or clothes because they think they may be contaminated, or refuse to eat food prepared by others.

**Checking**

Another very common form of OCD is checking. This can take many forms such as checking domestic appliances for example, plugs, cookers, electrical goods, and also doors, windows etc. It could involve over-checking work that you have done – it may be very difficult to finish something without checking it
repeatedly. Another common form occurs when driving – individuals retrace routes they have driven to make sure that they have not hit anyone without knowing. Checking obsessions can lead to extreme forms of reassurance-seeking behaviour, such as going round the same roundabout many times, or even ringing the police to make sure that an accident hasn’t been reported.

Cleaning and checking are both tied up with the idea that you might be responsible for causing harm to somebody, or to yourself. We will talk more about these ideas of responsibility and harm in the ‘Intrusive Thoughts’ section.

Order and Symmetry
People who have this form of OCD seem to feel the need to make sure that things are done in exactly the ‘right’ way, and that objects are in exactly the ‘right’ place. This may take the form of doing ordinary activities, such as washing or shaving, in a particular sequence, which has to be done right before they can do anything else. If the sequence is disrupted then it almost always has to be started from the beginning. Sometimes these rituals are accompanied by counting particular numbers, which assume a great significance in the person’s life. Or people need things to be arranged in a carefully-ordered or symmetrical pattern, and become agitated and upset if they are minutely displaced. People may need to spend a long time checking that things are ‘right’ before they can function.
Intrusive Thoughts

Sometimes the main problem people experience in OCD is the presence of thoughts which are very troubling to them. These thoughts appear in people’s minds spontaneously. The thoughts usually follow certain themes – often about sex or violence, or causing harm to others, especially children. The thoughts are repulsive to the person experiencing them. People try very hard to avoid having these thoughts, or to banish them from their minds, but the more they try to do this, the worse the thoughts seem to get. Sometimes there are no obvious behavioural compulsions in this form of OCD but people may carry out a lot of mental rituals to counteract the intrusive thoughts.

Obsessional Slowness

Obsessional slowness can occur when people want things to be ‘just right’. All actions have to be carried out in exactly the right way, and all decisions have to be absolutely right. Sometimes people think that terrible consequences may follow the wrong decision, and need to be completely sure that they are making the right one, even if this is something ordinary like choosing what to wear. It can take a long time to carry out ordinary everyday actions – even getting dressed can take a couple of hours - if you need to be sure that everything has been done in exactly the right way.

Hoarding

Hoarding is a less frequent form of OCD, but when it occurs can be extremely disabling. People find that they cannot throw away the smallest thing – junk mail, used tickets, old newspapers, even food past its sell-by date. The fear
underlying this seems to be that they might throw away something important. Hoarding can take over lives, as rooms and houses become filled with clutter that cannot be removed.

**Combinations of symptoms**

Many people experience more than one kind of obsessional symptom, although one type will usually be stronger and more problematic than the others. Sometimes the form of OCD can also shift from one type to another.

**How does OCD develop, and what keeps it going?**

As we have seen, it is very common for people to have worrying thoughts. What if that meat is off? What if there are germs around? What if I left the TV on when I went out? What if I left the gas on? Most of us are familiar with such thoughts, but most of us can deal with them without too much trouble. We feel a bit anxious, but the anxiety does not rule our behaviour.

For people with OCD, however, something very different happens….

Essentially, when someone who is prone to develop OCD has a thought like this, they become very anxious; the fundamental need is for individuals to reduce the anxiety they feel following the obsession. This is achieved via the compulsion. We know that when you carry out an action that makes you feel better, you keep doing it. So every time you carry out a compulsion, your behaviour is reinforced (to use jargon) by making you feel better, and you are likely to do it more. The sad truth is that although compulsions make you feel better in the short term, *they do not work in the long term*. The more you do the compulsions, the more you need to do them. It might have been that when the OCD was starting you only needed to check something once, or
wash your hands carefully once. But as it goes on, this simple reassurance stops working, and you need to do things more and more to feel better, until you are almost completely out of control of what you do. This is the case even if the compulsions that you carry out are things that you do in your mind rather than in the outside world.

By doing the compulsions you never get a chance to find out whether what you fear is really going to happen! People often realise that their worries are somewhat unrealistic, but the only way to really find this out is to face up to them without the compulsive behaviour.

The connection between the obsessional thought, the feeling of anxiety and the compulsion is illustrated below in Figure 1.

Figure 1: The basic vicious cycle of OCD
The obsession appears and triggers a feeling of anxiety. Compulsions such as washing and checking persist because they seem to ‘work’ by reducing or preventing the anxiety. However, carrying out the compulsion may briefly reduce anxiety, but in the long term it maintains the obsession and the urge to perform the compulsion again by reinforcing that the behaviour `reduces anxiety.

**Why do some people develop OCD?**

As we have already said, the experience of having unwanted thoughts is very common. The question is therefore; "Why does it become a problem for some people?"

Here are some likely answers:

We know that OCD often begins at times of stress, especially if it involves coping with extra responsibility, like having a child or caring for an elderly relative. OCD can also begin suddenly, for example, following an accident, bereavement or other traumatic event. After OCD has begun it usually gets worse if the person experiences any further life stress. There are also a number of other factors which seem to be a feature of people who develop OCD.

**Biological factors**

*Genetics:* It is possible that people may inherit genes that make it more likely that they will develop OCD. If a lot of people in your family have OCD, then this may be the case for you. However, we need to bear in mind that this may be because you have ‘learned’ OCD from seeing other people in your family with it, so that this may not be a direct effect of genes.

*Brains and Biology:* It is also possible that there are differences in the brain chemistry of people who develop OCD, making them vulnerable to this
disorder. As will be discussed later, there are certain drugs that work on the chemicals in the brain and seem to help reduce OCD symptoms.

**Personality**

It appears that some people who are liable to develop OCD may simply be more prone to becoming tense and anxious than most people. So an upsetting experience may be worse for them than someone else.

**Being frightened of risk**

Generally, people with OCD find it very distressing to take risks, particularly where this concerns others.

**Being frightened of uncertainty**

The world is often a very uncertain and unpredictable place, and the ‘not knowing’ and doubt can be very difficult to tolerate. People with OCD tend to find it much more difficult to cope with things being uncertain, and have a very strong need to feel in control, particularly if they think bad things are likely to happen.

**Feeling responsible**

OCD-prone people very often have a very strong sense of responsibility, both for themselves and for other people around them. They often need to to huge lengths to prevent harm occurring.
The impact of OCD on people close to you

There is no doubt that when OCD gets bad it can have a very big impact on the people around you. For instance, one patient was unable to let her husband and children into the house unless they took off all their clothes at the back door, as she believed they were contaminated. Another actually got the hoover out and hoovered her husband before she could let him into the house! Sometimes people can get very irritable and angry with spouses and children who don’t realise the importance of the obsessions, and might put things away in the wrong place or not put them away at all.

It is difficult for families to know what to do. Should they give in to the obsessions, and do what their partner wants? This will almost certainly keep the peace in the house a bit better, but it means that the obsessional partner will have less motivation to get better, and in the long term it can contribute to making the obsessions worse. Should the families resist the obsessions and carry on as normal? But this will make life very difficult for the obsessional partner, and will almost certainly lead to arguments and tears.

All of this can place a very great strain on relationships, with increasing anger and misunderstanding on both sides. It can also place a very great strain on children, not just because a parent is behaving in strange ways and getting angry, but because the child is learning to become obsessional themselves.
The first step for partners, and even for older children, may be to learn a bit about OCD themselves, and hopefully this booklet will help. Then, as you are taking part in this programme, it might be worth explaining to your partner what you are trying to do. Sometimes they will be able to help, giving you encouragement and pushing you on a bit. If you both decide that you would like to do this, then it is important for your partner to be guided in the programme by you, and not to force the pace unrealistically. But if things have got so bad that you can’t really talk about it without getting into an argument, then it would probably better for your partner not be too involved. Just letting them know that you are working on it yourself might relieve the tension, and make them feel a bit better about how things are going.
**Record of obsessions and compulsions**

From reading about the types of OCD, are you able to identify your own? Use the form to note down the obsession that comes you’re your mind and rate the discomfort that follows. Then describe the compulsion carried out in order to reduce the discomfort and how long it takes.

<table>
<thead>
<tr>
<th>Obsession (thought, word, image, doubt, impulse/urge)</th>
<th>Discomfort 0-100</th>
<th>Description of compulsion (usually an action)</th>
<th>Duration of compulsion</th>
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Part B: What can be done to help?

Introduction

Although OCD can take a hold of people’s lives, the good news is that there is hope! Drug treatments, particularly the newer drugs, can make a difference to OCD. If you are interested in trying medication, then your GP will be able to advise you on this.

The rest of this booklet will concentrate on psychological treatment. There are two main approaches, sometimes used alone and sometimes in combination. The first approach concentrates on your behaviour, and is called exposure and response prevention; the second approach concentrates on your thoughts, and is referred to as cognitive therapy.

Behavioural Treatments – Exposure and Response Prevention (ERP)

This treatment has two parts, working on the obsessions and compulsions. The first part of this is the exposure. We have talked about how people come into contact with something that makes them anxious (the obsession).

Normally, people go straight to the compulsion to make themselves feel better as soon as possible. But we know that this keeps things going. The idea of exposure is that you resist the temptation to carry out the compulsion, and that you will start to let yourself come into contact with the things that make you feel anxious.
The second part is response prevention. This is when you do things that make you anxious, **you do not carry out the compulsion**. In other words, you do nothing to make yourself feel immediately better.

Although this may sound harsh, when people confront things that make them anxious, after a while the anxiety starts to wear off. This is exactly the same principle as the treatment of phobias – for example, someone who was frightened of spiders would be encouraged to look at pictures or words about spiders, and eventually look at a live spider. When you are exposed to things that make you feel anxious, and if you can hang on in there without running away or doing the compulsion, then the anxiety starts to wear off!

So the principle behind exposure and response prevention is very similar to the treatment of phobias. You need to expose yourself to the things that make you feel anxious, without doing anything to make yourself feel better.

Before we go on, it is important to look at the following diagram. What normally happens when you come into contact with the trigger is that you get anxious (Labelled 1. Trigger on graph below). When you carry out the compulsion, this anxiety is reduced very quickly and very effectively (Labelled 2. Compulsion on graph). Many people fear that if they don’t carry out the compulsion, then their anxiety may never reduce, or may even carry on going up (Labelled 3. Perceived anxiety). In fact what happens is that the anxiety does stay high for a while, but then, **without you needing to do anything**, it will start to come down, and will eventually reduce to exactly the same point that it
would have done if you had carried out the compulsion (Labelled 4. Actual anxiety). This means that over time you will start to recover from the anxiety without needing to do the compulsion at all.

This diagram shows the difference in our predicted anxiety and actual anxiety in the course of an OCD compulsion.

1. Trigger - presentation of obsessional thought/object – anxiety goes up
2. Compulsion - when compulsion is carried out anxiety decreases rapidly
3. Predicted anxiety - if the compulsion is not carried out people predict that anxiety will increase indefinitely
4. Actual anxiety - in fact anxiety decreases over time without compulsive activity

Now, normally people find it very difficult to do the exposure work, and it is important to make sure that you do not try to do too much, too soon. Although occasionally drastic measures are called for, it is much better to expose yourself in small and manageable steps – otherwise, you risk finding that the experience is so horrible you just don’t want to go on with it. You may find the
OCD Fear Hierarchy form (Appendix 1) useful when putting your compulsions in order of how difficult it might be to overcome them.

**SUDS – or Subjective Units of Discomfort.**
This is a measure that you can use to keep track of how you are feeling and help to plan your treatment. The SUD just means how bad you feel. It can vary in content from person to person with a mixture of anxiety, anger, agitation, misery etc. Only you know exactly what it is like for you. But however you feel, it should be possible to make a rough judgment of how bad it is. SUDS can be rated from 0 to 100. 100 is the worst that you can imagine feeling, and 0 is completely fine. You may find the ‘Form for Monitoring Exposure and Response Prevention (ERP)’ in Appendix two at the end of this booklet a helpful aid in recording SUDs during ERP.

Now – back to exposure and response prevention…

**Planning your exposure programme**

1. Write out a list of all the different things that make you anxious; the ‘Record of obsessions and compulsions’ (page 15) that you completed earlier may help here.

2. Put these in order of how anxious they make you, starting with the least challenging. The ‘OCD fear hierarchy form’ in Appendix one may give useful structure.

3. Rate each step using the SUDS – ie rate how bad you would feel from 0 – 100 if you were to do them.
4. Choose something in the range of 30 – 40; that is, something that will make you feel a bit bad, but will not be too much for you to manage.

5. Now the task is to expose yourself to the thing that makes you anxious without doing anything to make it better. Decide exactly what you are going to do, and then DO IT!

6. Rate your SUDS straight away and take a note of how high the rating is. Now wait five minutes, and rate the SUDS again. Keep a note every five or ten minutes of how bad you are feeling. Although you may find within the first few minutes the rating will go up, after a while it will start to come down as your anxiety starts to wear off.

The form for monitoring exposure and response prevention (ERP) in Appendix two may be useful for this part of the programme.

Remember that exposure and response prevention can make you feel very bad indeed, particularly at the beginning when you are not confident that it will work and not used to tolerating the horrible feelings of anxiety. But Psychologists have shown many times, that if you can make yourself go through with this programme, then you will start to feel much better and you will feel much less need to carry out the compulsions. There is no substitute for suffering, but it does work!

**Which types of OCD respond best to this approach?**

Exposure and response prevention is particularly useful in the treatment of cleaning and checking types of OCD. They can also be used for helping problems with order and symmetry, hoarding, and slowness, but it is slightly
harder to apply them to these problems and if you are reading this booklet on your own you may find that you will need some advice from a professional about how to go about it.
Cognitive Treatments Part 1: How to tackle intrusive thoughts

As we discussed in Section A, some people are very troubled by intrusive thoughts even though they do not carry out obvious or extensive compulsions. People do, however, tend to avoid situations which might tend to trigger the thoughts.

For example:

Elizabeth couldn’t hold her newborn granddaughter without having thoughts that she might harm her with a knife. These thoughts distressed and frightened Elizabeth so much she soon refused to be in a room alone with the baby, let alone hold her.

David had thoughts when in any busy public area that he might lash out and punch one of the strangers walking towards him. Again, the idea of this distressed him to such a degree he began isolating himself from others. At the very least, he would make sure that he always kept his hands in his pockets when he infrequently left his house.

Psychologists studying this realised that when they asked people who were not troubled by obsessions of any sort, about whether they ever had strange thoughts that just came into their minds, almost everyone said yes. Common themes amongst these thoughts were identified: ideas or images about sex; particularly horrible and repulsive ones; themes of violence or harm, particularly thoughts and images of harm coming to you and other people, or you causing harm to others.
As we can see, these common themes that people experience are very similar to the kinds of troubling thoughts that are common in those with OCD. So why do some people have these thoughts without developing obsessions, while others are so troubled by them? The answer seems to lie in the attitude which people have to their thoughts. For example, one mother might have an image of herself harming her children and think “Fancy thinking such a weird thought, I certainly don’t want to do that!” But another might think “Oh my God, what a terrible thing to think – if I’m thinking that it must mean that I want to do it! How can I think that, I must be a terrible evil person!”. In the former case, the mother would have the thought, but would not worry about it, and would not have to do anything as a result. But in the second case, the mother would worry a great deal. She would start to watch her thoughts, to make sure that she wasn’t thinking them. She would struggle to dismiss the thoughts and get them out of her mind. She would also start to avoid situations where she might have the thoughts, and where she thought she might harm her children.

We now know that the more you try to suppress the thoughts, the worse and more frequent they get. So the irony is that the more the second mother tries not to have the ‘bad’ thoughts, the more she has them.

You can demonstrate this effect to yourself with any kind of thought. For the next two minutes, try not to think about pink elephants.
How did it go? Did you think of pink elephants at all? Did you find that the effect of trying not to think something, actually brings it into your mind, rather than keeping it out.

The unfortunate effect of this is that as the thoughts become more frequent, the person suffering from them makes more and more harsh judgements about themselves. The more frequent and more unpleasant the thoughts are, the more that ‘proves’ to the person that they are bad, or is going to carry them out.

The thoughts that become obsessions are usually associated with areas of life where people have very high standards, so that the presence of such a thought goes against everything that people believe in about the world or themselves. For instance, blasphemous thoughts are much more common in very religious people, to whom such thoughts are repugnant.

So what can be done?

The first step is for you to think very carefully about the explanation above, and to realise that it is normal to have extraordinary thoughts, and does not mean that you are bad, mad, dangerous, or anything else. In fact you are just troubled, and are probably more troubled by the thoughts than other people because you have high standards for yourself and the world, not because there is something wrong with you.
The next step is to stop fighting the thoughts. When they come into your mind, instead of panicking and thinking “Oh no, I mustn’t think that, I must stop!”, try to keep calm. Remind yourself that it is ok to have the thoughts and let them drift through your mind. If you feel able, you could even try something similar to the exposure described earlier. Set aside ten minutes or half an hour a day, and deliberately make yourself have the thoughts. Don’t try to avoid or stop them. Even though it will make you very anxious and uncomfortable at first, you will find that you somehow get used to the thoughts, and that they will stop seeming so frightening.

Finally, if the intrusive thoughts have made you avoid things, start to work on reducing this avoidance, by gradually making yourself do things you have stopped doing or go to places you have stopped going.

“But what if I carry the thoughts out?”

Many of the intrusive thoughts that we have described concern the thought or image of you doing something. This might be causing harm to someone else, or to yourself, or doing something completely socially unacceptable. It is very important to realise that these obsession thoughts are never carried out.

One way to think about it is like this: Mostly people believe that there is a direct link between thought and action, so we could draw it in a diagram like this:
Thought ⇒ Action

But in fact, there is another part of the chain that most of us are not aware of – in order to do something, we have to intend to do it. So the diagram would look like this:

Thought + Intention ⇒ Action

No matter what you think about, it is only the introduction of the intention – meaning to do the action, planning it, etc – that leads to action, not the thought itself.

Now it is very easy for Psychologists to say this, and much harder to believe it, particularly if you have always taken steps to make sure that you don't carry the thoughts out. But the only way in which you can convince yourself that you can have the thoughts and not carry them out is to start to let yourself think them, and to put yourself into situations where you might have them.

Thoughts are just thoughts!

The common message in all of this is that thoughts are just thoughts – things that go on in your mind. There is a great temptation amongst Psychologists to think that all thoughts are meaningful and significant, and there is also a great temptation to think that they are related to things that go on in the real world. But they are not! You can think anything you like in your head without it meaning anything or having any impact on the world at all. Thoughts are just thoughts!
Cognitive Treatments Part 2: Dealing with ‘Thoughts about thoughts’

When people have obsessional thoughts it is bad enough, but there also seems to be an extra layer to the problem. When we experience obsessional thoughts we tend to think that we must be really bad or mad, to be thinking such things. Or perhaps we might think that we mean the thoughts, or that we really want the things that we think about to happen. This means that we are extra frightened.

So what can be done about these?

Very often, if people can be helped to see obsessions for what they are, then they worry less about having them and that seems to help the obsessions to go away. So we need a way of helping to identify the 'thoughts about thoughts', and try to change them.

The first step is to keep a diary of your thoughts, writing down exactly what is going through your mind.

Once you have identified the thoughts, the next step is to learn to challenge them. This can be done in a number of ways. For instance, if we take the thought “I had an image of drowning my daughter; I must be a really bad person,” we could use the following process of investigation:

Thought about thought: “I had a bad thought therefore I am a bad person”
Q: Is there any evidence that I am a bad person? Here you might try to think of all the bad things that you have done. How often have you hurt someone on purpose? How many criminal things have you done? How bad were they?

Q: Is there any evidence that I am not a bad person? Here you might try to think of all the reasons to believe you are not bad. Have you ever done anything kind for anyone? Have you ever felt sorry for anyone in trouble, or tried to help them?

Q: Is there another way of seeing things? Remembering everything that you have learned about obsessions, remind yourself that thoughts are just thoughts and do not mean that you want to go along with them.

You can also try to weigh up the probability that you are a bad person. Have you done more bad than good things? Or the other way round? If you were in a court of law, would you manage to convince the jury that you were a bad person?

You can also try thinking about what a friend would say to you. Would they think you were bad because of these thoughts? Or if your friend was having the thoughts, what would you say to them? Would you condemn them as bad, or would you be more understanding?
You could also **try thinking about the effects of thinking you are bad.**

Here you might notice that when you have the thought you might tend to avoid bathing your daughter, and feel that you should not be close to her. This means that you will add to your problems by making yourself feel guilty.

**How can I test these thoughts out?** The crunch is that now is the time to take a risk! Hopefully by now you will have summoned up quite a lot of evidence that you are not bad, and quite a lot that you are a good person. So you need to convince yourself of this by behaving as if you are a good person, and really bringing the message home that you don’t need to worry about the thoughts.

In summary, the questions to ask yourself are

- **Is there any evidence for this thought?**
- **Is there any evidence against it?**
- **Would it stand up in a court of law?**
- **What would I say to a friend who thought like this?**
- **What would a friend say to me about it?**
- **What are the effects of thinking as I do?**
- **How can I test this out to show myself that the thoughts are false?**
Dealing with ideas of responsibility and blame

A similar kind of procedure can be used to deal with ideas that you are totally responsible for things that might happen. What is the evidence that you are totally and solely responsible for what might happen? What is the evidence that other people may play a part in things? Make a list of all the people who are involved in the things you are worried about – yourself, your spouse, the electricity board, other drivers on the road, careless cyclists or pedestrians, for example. How much does each contribute to what might happen? How can it be up to you to control what other people do? In some cases you may be worried about what insurance companies call ‘acts of God’ – floods, for example. How can these be your responsibility? Try to remind yourself that responsibility for these things does not rest with you.

Thought-Action Fusion

As we described above, sometimes people can get in a great muddle about the relationship between thinking and action, and believe that if they think something bad it might be more likely to happen, or it is just as bad as doing it on purpose.

Likelihood Thought-Action Fusion

If you are afraid that thinking something might make it happen this is known as likelihood thought-action fusion. Try looking out of the window at the building next door. Think about this falling down. Get a really strong picture in your mind that this will happen. Now look again. I am prepared to bet anything you like that the building is still standing. This is the same with any
other kind of prediction – thinking is only something that goes on in your head. *It does not have an impact on the real world.*

*Moral Thought-Action Fusion*

If you think that you are bad to have a particular thought, try looking at the earlier section on ‘How to tackle intrusive thoughts’. This attempts to explain the idea that thoughts are just thoughts, and you are not bad to think them. But you could try another experiment. Imagine your neighbour is unwell and needs some shopping done for her. *Think* about doing it. Does just thinking about this make you a good person? Will she be grateful that you were *thinking* about helping her? Will thinking about it mean that she has milk for her tea? The answers are obvious. In order to be good and helpful you have to *do* the action, not just think about it. The same is exactly true for unpleasant thoughts. These thoughts cannot harm anyone, and you are not bad to have them!

**Control**

As we described earlier, sometimes people carry out compulsions because it gives them a feeling that they can control bad things going on around them, even when they cannot. Sometimes these compulsions can act as a way of avoiding tackling problems – instead of meeting the real problem head-on, you feel so anxious that you retreat into obsessions and compulsions instead. Like many aspects of OCD, this can make you feel better whilst you are doing it, but does not help much in the longer-term. It could be very important to try and face the anxiety that the real problem is causing, and see if there is
anything that could be done. It may be that once you have faced the problem there are other people around who could help too – GPs, Counsellors, the Citizens Advice Bureau, for example, might be good starting places.

**In summary**

Please remember that although OCD can seem overwhelming and incomprehensible, it need not be quite so bad as all that. We can make psychological sense of obsessions and compulsions, and there are things that you can do to try and tackle them. We realise that it is rarely easy – often changing what you do, particularly if you have been doing it for a long time, can be very demanding and can make you feel very bad. But all our experience is that as you start to make changes they tend to get easier, and that if you can stick at it you will quickly start to feel a lot better.

**Good luck!**
Appendix 1: OCD fear hierarchy form

<table>
<thead>
<tr>
<th>Rank</th>
<th>Situation</th>
<th>Fear Rating 0-100</th>
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Appendix 2: Form for Monitoring Exposure and Response Prevention (ERP)

<table>
<thead>
<tr>
<th>Date &amp; time</th>
<th>ERP task</th>
<th>SUDS: first exposure</th>
<th>SUDS: 5 mins</th>
<th>SUDS: 10 mins</th>
<th>SUDS: 30 mins</th>
<th>SUDS: one hour</th>
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This is a measure that you can use to keep track of how you are feeling and help to plan your treatment. The SUD just means how bad you feel. It can vary in content from person to person with a mixture of anxiety, anger, agitation, misery etc. Only you know exactly what it is like for you. But however you feel, it should be possible to make a rough judgment of how bad it is. SUDS can be rated from 0 to 100. 100 is the worst that you can imagine feeling, and 0 is completely fine.