Dorset HealthCare University NHS
NHS Foundation Trust

steps 2 wellbeing

Coping with OCD Group Manual

Name:

Facilitators' names:

Contact Details
General: dhc.steps2wellbeing@nhs.net
Southampton: Telephone for self-referrals: 0800 612 7000; Telephone for information and cancellations: 02380 272000; dhc.sstw@nhs.net
Bournemouth or Christchurch: 0300 790 0542; dhc.bc.s2w@nhs.net
Poole: 0300 123 1120; dhc.pped.s2w@nhs.net
Purbeck or East Dorset: 0300 123 1120; dhc.pped.s2w@nhs.net
Weymouth, Portland, Mid or North Dorset: 0300 790 6828; dhc.west.admin.s2w@nhs.net

Welcome to the “Coping with OCD” course

You may be feeling a bit anxious on starting the group, most others will be (maybe the facilitators too!). However, we have run similar courses many times, and found that most people who complete it have benefitted in some way from it. The techniques included in the course are based on sound evidence to prove that they are effective for people who are experiencing obsessive-compulsive symptoms. Here is some information about getting the most from the course.

This is a 12-session course, and to get the most from it it’s really important to attend all 12 sessions. However, we realise that from time to time things happen that may stop you attending a session. Firstly, please ring in, ahead of the session if possible, and let us know; if we do not hear from you, we will try to call you. If you miss more than two sessions you may be asked to leave the group, but we will try to offer you an alternative, although you will need to start again. If you do miss a session, make sure that you read the relevant pages of the manual, and try to complete the homework tasks.

Who are we?

Steps to Wellbeing is the local NHS service for people experiencing anxiety or depression. We’re a friendly team of mental health professionals, and we provide a mixture of group work and one-to-one work both in person or face to face.

This is a “Step 3” group. Step 1 is your GP. Step 2 is mainly delivered by phone. Step 3 is for problems that cannot be resolved at steps 1 or 2. If you have previously been to a Step 2 group, the main difference is that at Step 3, although there are some ideas that we will want to explain to the group each week, the dynamic in the group comes from what the participants bring to it. We will look to you to be willing to take part in exercises; and to share some of your thoughts and experiences, both about how your problems affect you, and how you get on trying out these techniques. However, there is never any pressure to share anything you don’t want to.

NHS Stepped Care Model:

If things get bad: If you experience suicidal thoughts at any point, please ask to talk in private to the facilitators. If you have ever experienced such thoughts before, think about making a safety plan. Things people find useful to include in a plan might be: how to look after myself (e.g. making a warm drink; eating hot food; taking a bath or going for a walk or listening to music); seeking support from others (is there a trusted friend or family member you can talk to?); and be ready to ask for professional support, this would be your GP - or their out-of-hours service – and the services listed below. The Samaritans provide a listening service for those in need. Emergency psychiatric assessment is also available from A&E departments. Here is a list of professional support available to contact:

- **Samaritans – call 116123**
- **Shout Crisis Text Line – text 85258**
- **Call 111 - if you urgently need medical help or advice but it is not a life-threatening situation**
- **Call 999 - if you or anyone else is in immediate danger or harm**
- **Your GP**
- **Stay Alive (suicide prevention app)**
- **Calm Harm (app to manage self-harm): https://www.nhs.uk/apps-library/calm-harm/**
- **DistrACT (app for information and advice about self-harm and suicidal thoughts): https://www.nhs.uk/apps-library/distract/**

If you live in Southampton:	**If you live in Dorset:**
• **The Lighthouse - https://www.southernhealth.nhs.uk/locations/thelighthouse/** • **Solent Mind – for peer support**	• **Call Connection, a local 24/7 helpline run by Dorset HealthCare: 0800 652 0190** • **Visit the Retreat: Hahnemann Road, Bournemouth BH2 5JW**

An Overview of the Course:

Week 1 – Cognitive-Behavioural Therapy and OCD

Week 2 – Understanding Anxiety

Week 3 – Anxiety & Relaxation Skills

Week 4 – Exposure and Response Prevention (part 1)

Week 5 – Exposure and Response Prevention (part 2)

Week 6 – Negative Thinking (part 1)

Week 7 – Negative Thinking (part 2)

Week 8 – An OCD Formulation

Week 9 – Challenging negative thoughts

Week 10 – Responsibility, Guilt, Shame and Blame

Week 11 – Relapse Prevention

Week 12 – Review and Evaluation

Week 1 – Cognitive-Behavioural Therapy and OCD

Ground rules:

In the first session you will be asked to take part in an exercise to agree on some group ground rules. These are about how to keep the experience of being in the group a safe, effective and pleasant experience for everyone. Every group makes up their own ground rules, and each set is therefore unique. This page is for you to write out what your group decides on.

Just in case you miss the first session, the sort of things that it will probably include will be:

One person at a time to speak; no such thing as a silly question; show respect to each other; prompt time keeping (especially coming back after coffee break); although you can share the learning from the group, individual's personal stories are not to be shared with anyone outside the group; switch mobiles to silent; phone in to the office if you're going to be away.

Our ground rules:

Useful Telephone Numbers:

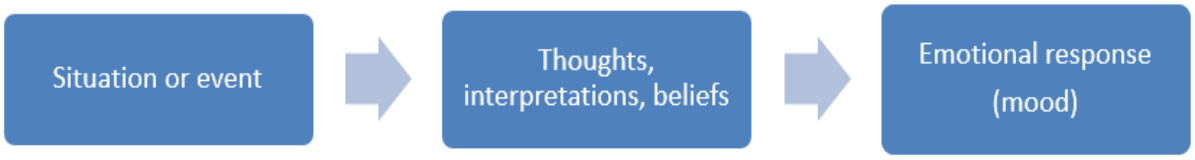
e.g. my GP surgery

My Personal Safety Plan

Signs that my mood is deteriorating:
What steps can I take to manage this? Where can I get support?

What is Cognitive Behavioural Therapy (CBT)?

CBT is a type of talking therapy that has been shown to be very effective in helping people with both depression and anxiety.
Most of us believe that events, situations and the behavior of others cause us to feel emotions like anxiety, sadness or anger. You might recall hearing yourself saying things like "*She/he wound me up*" or "*I'm upset because I didn't get the job I wanted*". If this were true then everybody in a particular situation would react the same way, but this isn't what happens. People can have the same experience but feel very differently about it.
Our emotional response is influenced by what a situation means to us, by the interpretation and beliefs that we have about the situation.



The way we feel is affected by the way we think. Our thoughts and feelings often affect what we do, and this can then become part the problem. For example, someone experiencing really negative thoughts about themselves such as "*I'm a failure", "No one likes me*" may feel upset, sad or ashamed. As a result of these thoughts and feelings, they may stop going out as much and spend more time on their own. This in turn will cause them to feel even worse about themselves, which leads to more negative thoughts (e.g. "*I'll always feel like this*"), and so they get caught in a cycle where things feel worse and worse. CBT helps you to understand how your thoughts, mood and behaviour are connected to each other, and the patterns or vicious circles that may be keeping your difficulties going. CBT also gives you tools to start breaking those cycles, challenging negative thinking, changing unhelpful behaviours, and improving emotional wellbeing.

How Can CBT Help?

Cognitive behavioural therapy (CBT) can help you make sense of overwhelming problems by breaking them down into smaller parts.

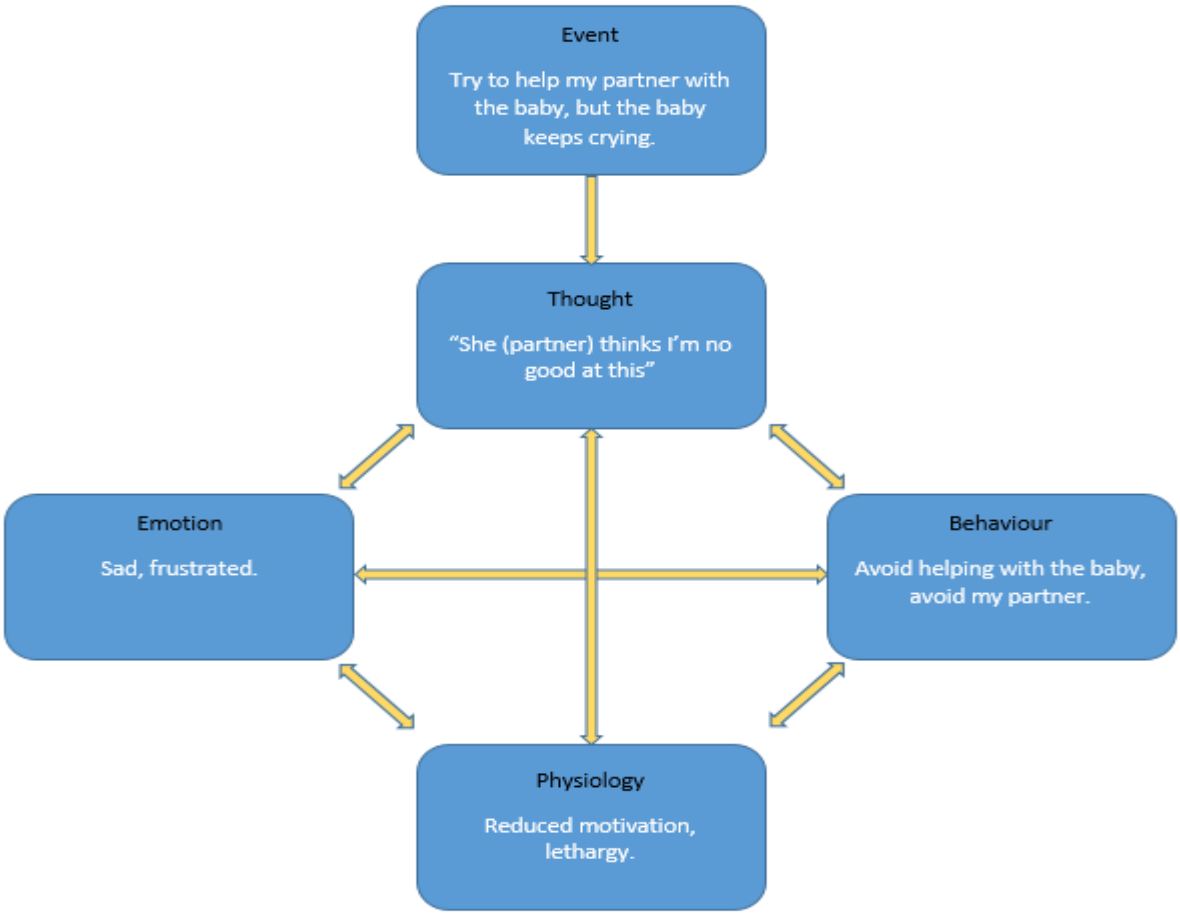
In CBT, problems are broken down into 5 main areas:

- Situations/Triggers
- Thoughts/Images
- Emotions
- Physical Sensations
- Behaviours

CBT is based on the concept of these 5 areas being interconnected and affecting each other. For example, your thoughts about a certain situation can often affect how you feel both physically and emotionally, as well as how you act in response.

CBT can help you break this cycle by identifying unhelpful patterns of thinking and behaviour, which could be maintaining the problem(s). During these group sessions you will learn techniques to help you change these patterns, to help you achieve your goals and overcome OCD.

The Cognitive-Behavioural Therapy (CBT) Five Areas Model



Events or **triggers** are the situations that cause us fear. We interpret those situations with certain **thoughts**. If those thoughts are negative thoughts, they may cause negative emotions – such as **anxiety**. As we become more anxious there are a series of **changes in the body**. The anxiety and the body changes may make the negative thoughts more catastrophic. When people get caught in this vicious cycle, they often adopt **behaviours** aimed at feeling safer: these are usually about **avoiding** such situations, **exiting** or **neutralising** (only focussing on the safe part of the situation, e.g. talking to a known friend at a party).

Have a look at this video: https://www.youtube.com/watch?v=UP8JwNYZBpI

Exercise: try to match each of these parts of a problem to one part of the chart:

a) Julie cleans the kitchen again – for the second time this morning

b) Julie's breathing is shallow and rapid

c) Julie feels really tired

d) Julie thinks about the dirt in the kitchen; dust on the shelves and dust in the carpet. She also thinks about Pat asking to use the loo

e) Julie feels sick in the pit of her stomach

f) Julie's friend, Pat, rings the doorbell unexpectedly during the day

g) Julie feels real fear

h) Julie ignores the ringing doorbell. She stays very still

Triggers / Situations	Thoughts / Images	Emotions	Physical Sensations	Behaviours

OCD
Obsessive Compulsive Disorder

Obsessive Compulsive Disorder (OCD) is an anxiety disorder dominated by obsessions (intrusive thoughts, images) and compulsions (rituals, urges and behavioural responses to the thoughts).

A lot of people with OCD feel very responsible for preventing a terrible thing from happening (e.g. I must keep bacteria away from my family otherwise they might become ill or die and it will be my fault"). Others do not have these catastrophic thoughts, but might feel very uncomfortable and become increasingly anxious and distressed if they don't do what their head is telling them to do.

Compulsions can be 'overt' or obvious behaviours (cleaning, touching, moving things), or 'covert' hidden mental rituals such as counting, repeating things, questioning or checking. A few people only experience obsessions, and a small minority only compulsions.

There are some other variants of OCD, such as perfectionism, trichotillomania (hair pulling), compulsive skin picking, and Body Dysmorphic Disorder (BDD) in which the person believes a particular part of their body is defective and they constantly check, scan, and plan, or make attempts to hide or change the 'defect'.

Example of a vicious cycle of OCD

Can you try to think about examples of obsessive thoughts and compulsive behaviours?

Obsessive Thoughts	Compulsive Behaviours

Common Obsessions	Common Compulsions
- Contamination fears of germs, dirt, etc.	- Washing
- Imagining having harmed self or others	- Repeating
- Imagining losing control of aggressive urges	- Checking
- Excessive religious or moral doubt	- Counting
- A need to have things "just so"	- Hoarding

So, how does this "CBT" work then?

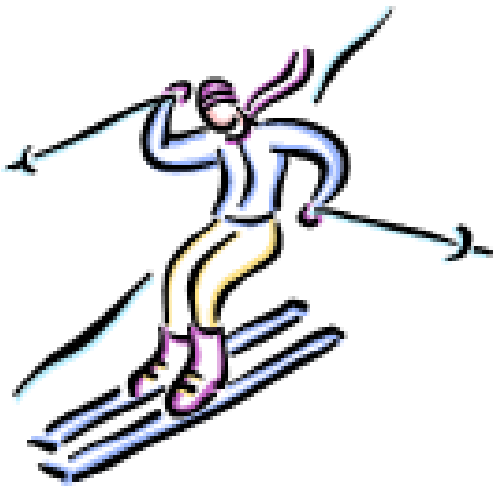
Change can be challenging, and it is normal to think "*I can't see this helping me*" or "*I can't do it*", particularly if you are caught in the vicious cycle! Asking for help can be difficult, and it can be hard to find the motivation to change. Any change takes effort, but the rewards can be huge.

Discussion Point: Making Changes.

Think about other times in your life when you have made a change - e.g. giving up smoking, starting a new job, learning to drive, taking up a new hobby. What can you take from these experiences to help you now?

The Ski Slope Analogy

Think about a mountain covered in fresh fallen snow. As people start skiing down the slopes, paths will appear. People tend to follow each other, and during the day, well-worn routes will start to appear, with the snow becoming flattened and smooth. The easiest and fastest way down the mountain is to follow these paths.

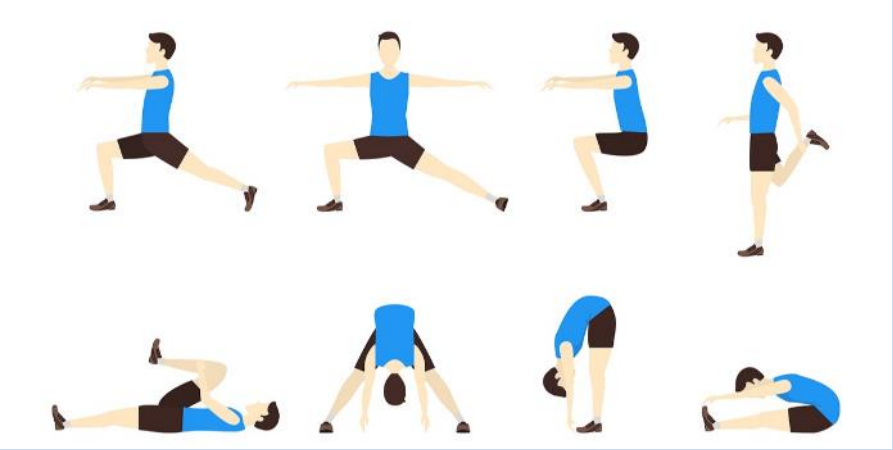


But what if you want to take a new route, and go “off-piste”? This involves carving out a new path through the fresh snow. This is initially slower and harder work, but you can still get down the mountain. You may find a better route, one with more impressive scenery, or a more exciting ride. Although this may require more effort in the short-term, with repetition this path too will become well-worn, and the journey will become easier and faster.

A note on weekly tasks

An important part of CBT is completing weekly tasks (often referred to as “homework”). The weekly tasks set for the group will help you apply the course material and CBT techniques to your everyday life. It is really important to practice the techniques in between sessions, to help you get the most out of this course. Each session will start with a review of the previous week’s task.

Home practice is an extremely important way to get used to using the skills and learning from the sessions to everyday life. It is like when you go to a physiotherapist, and they give you exercise to do on a daily or weekly basis to feel better physically. From this point of view, mental health is not too different from physical health: we need to incorporate new practises, routines, thinking styles in our daily life to allow our brain to gradually feel and react differently to our stressors and triggers.



Scientific research suggests therapy works best for clients who are committed and motivated to practise CBT skills regularly – meaning that the better you engage with home practice, the more likely it is to feel better!

Therefore, it is extremely important that during our sessions we recognize and discuss any potential obstacle that you might find in engaging with your home practice.

How do you feel about completing homework between our sessions? Do you think that there might be any potential difficulty or obstacle in doing this?

Week 1 - Task:

5 areas model

Diary keeping is an important part of CBT. Diary keeping has several advantages:

- It helps focus you on the things that you have learned, and thereby helps learning
- It boosts self-insight through writing and as you become more self-reflective
- It helps to capture negative thinking as it's then easier to challenge it

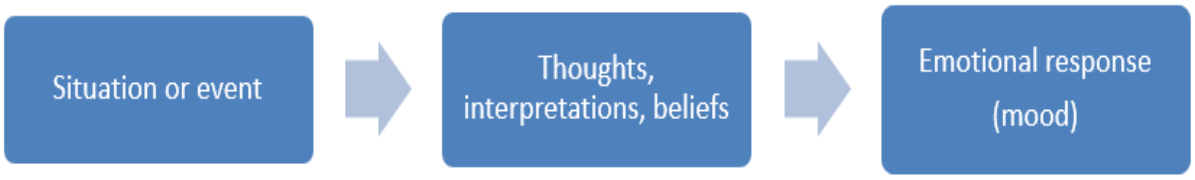
This week we are starting with a very simple diary.

Try to identify one situation in the week in which you experienced distress, discomfort, worries or negative emotions – it can be something small. Then try to complete this:

SITUATION/TRIGGER - Where? When? Who with? What happened? How?
THOUGHTS & IMAGES - What went through my mind at that time? What disturbed me? If I had those thoughts/images/memories – what did that say or mean about me or the situation?
EMOTIONS - What emotion did I feel at that time? What else? How intense was that feeling? (0 – 100%)
BODY/PHYSICAL SENSATIONS - What did I notice in my body? What did I feel? Where did I feel it?
BEHAVIOURS - What helped me cope and get through it? What didn't I do or what did I avoid doing? What automatic reactions did I have? What would other people have seen me doing?

Week 2 – Understanding Anxiety

In the first session, we saw how our emotional response is influenced by what a situation means to us, by the interpretation and beliefs that we have about the situation; how the way we feel is affected by the way we think.

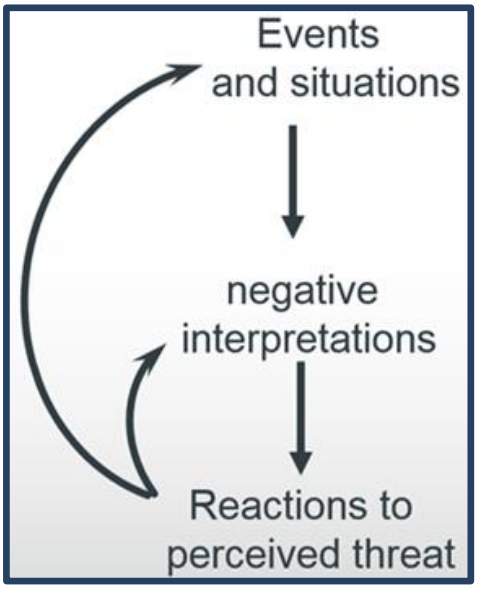


Let's think about an example. Let's say that two friends – Tim and Jen - are going to the park on a very sunny day, when the park is full of people – and of people with dogs. Now, let's imagine that Tim really likes dogs, while Jen has a very intense fear of dogs, maybe because she was bitten by a dog when she was a child.

Let's try to imagine what their interpretations, beliefs and thoughts and their reactions might be:

Event/Situation	Tim - He likes dogs	Jen – She has a fear of dogs
Going to the park. The park is full of people, and a lot of people are there with their dogs.	Interpretations, beliefs and thoughts:	Interpretation, beliefs and thoughts:
	Feelings and reaction:	Feelings and reaction:

What usually happens when we feel anxious is that we make a negative interpretation of a situation, which means that we assess a situation as dangerous, threatful:



When we feel anxious, this “assessment” of a situation usually takes into account four main elements:

Anxiety and Threat: Understanding the Severity of Anxiety	
Anxiety is proportional to the perception of danger, that is:	
Perceived likelihood it will happen	Perceived “awfulness” if it did
Perceived coping ability if it happens	Perceived rescue factors

- Perceived likelihood it will happen. How likely is this to happen?
  - *Example: if I don’t check everything I do at work many times, I will make a lot of mistakes*
- Perceived “awfulness” if it did. If it happens, how bad will it be?
  - *Example: if I make a mistake at work, like misspelling some words when I send an email, I will lose my job and I will not be able to buy food for my children anymore*
- Perceived coping ability if it happens. Will I be able to cope if it happens?
  - *Example: I will feel humiliated and lose my job, and I will not be able to find another one. My life will be ruined*
- Perceived rescue factors. Is there anything or anyone in that situation that might be able to help me cope?
  - *Example: it will be fully my responsibility. I will not be able to rectify the mistake, people will blame me and I will end up all by myself*

Calculating the probability of harm

A helpful way to challenge what-if thinking is to estimate the perceived probability of the horrific event occurring versus the actual probability.

Let's try with Michael's example: "*What if a piece of paper flies out of my car and causes a horrific accident and I get arrested*?"

Michael estimates that to be 50%, meaning that he believes there's a 50% chance that a piece of paper blowing out his car window would result in a horrific accident.

To challenge this belief, Michael constructs a very detailed downward arrow sequence of exactly how he perceives this horrific event occurring:

A small piece of paper accidentally blows out of the window of my car
↓
The paper is picked up by a gust of wind.
↓
The paper flies in front of another car.
↓
The paper lands on the windshield of a moving car.
↓
It lands in the exact spot to block the vision of the driver.
↓
The driver is so startled that he loses control of the car.
↓
The car crashes into another vehicle.
↓
The teenager is killed in the crash.
↓
A forensic investigator at the scene of the accident finds a piece of paper lying at the scene.
↓
The investigator decides that the paper is suspicious.
↓
My name and address are on the paper, connecting me to the accident.
↓
The police arrest me, saying that by throwing paper out of my car, I caused the accident.
↓
I'm tried and convicted of manslaughter.
↓
The judge sentences me to five years in prison and a huge fine.
↓
I go to jail for five years, and I spend the rest of my life living with the perpetual guilt of causing harm to someone through my irresponsible act.

The next step would be to go through all the statements and assign the probability that it could occur. For example:

What if a piece of paper flew out my car?	Probability (0-100%)
A small piece of paper accidentally blows out of the window of my car	20%
The paper flies in front of another car.	5%
The paper lands on the windshield of a moving car	3%
It lands in the exact spot to block the vision of the driver.	2%
The driver is so startled that he loses control of the car.	10%
The car crashes into another vehicle	10%
The teenager is killed in the crash	30%

To find the probability of the entire sequence of events occurring, you multiply the probabilities of all of the separate events. For the purposes of multiplication, each percentage should be expressed as a decimal.

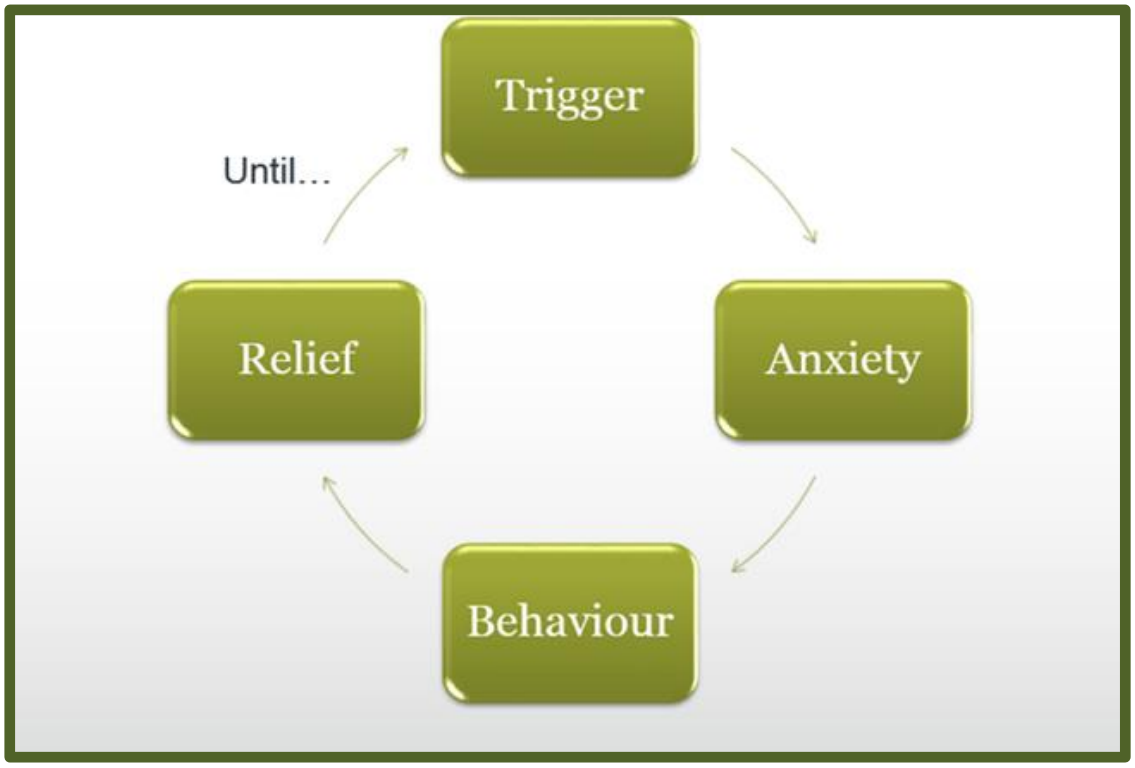
In Michael's case, he would multiply 0.20 by 0.05 by 0.03 and so on, down the entire sequence.

Total = 0.000000018 % vs. 50% originally

This exercise helped Michael see that the actual probability of his feared event was nowhere near the 50% probability he estimated before the exercise. This allowed him to acknowledge that his intrusive thoughts of causing harm and danger through negligence are greatly exaggerated ideas, not to be given any credence.

In the first session, we looked at the 5 areas model of Cognitive-Behavioural Therapy and at the vicious cycle in OCD. Let's have a look now at how we can describe a generic vicious cycle for anxiety:

Vicious Cycle of Anxiety



➔

The **behaviour** in this cycle is what we define as **safety-seeking behaviours (SBs).** We can recognize safety-seeking behaviours because they provide a short-term relief, but they maintain or even worsen anxiety in the long-term, 1) because they prevent us from getting used to the situation, 2) because fear and beliefs about threat are unchallenged or even reinforced, and 3) because they can cause other unintended consequences.

Some of the most common safety seeking behaviours are:

Avoidance

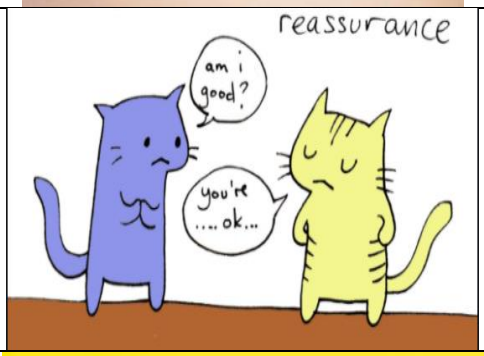
- It provides short-term relief but keeps anxiety going in the medium and long-term
- The belief remains unchallenged
- It prevents you from getting used to the situation

Checking

- It provides short-term relief but keeps anxiety going in the medium and long-term
- The belief remains unchallenged
- It prevents you from getting used to the situation
- It makes you feel less certain in the future

Reassurance-seeking

- It is a form of checking
- It provides short-term relief but keeps anxiety going in the medium and long-term
- The belief remains unchallenged
- It prevents you from getting used to the situation
- It undermines confidence
- It makes you feel less certain in the future



Procrastination

- It provides short-term relief but keeps anxiety going in the medium and long-term
- The belief remains unchallenged
- It prevents you from dealing with/getting used to the situation

Mentally Reviewing Events / Mental Checking

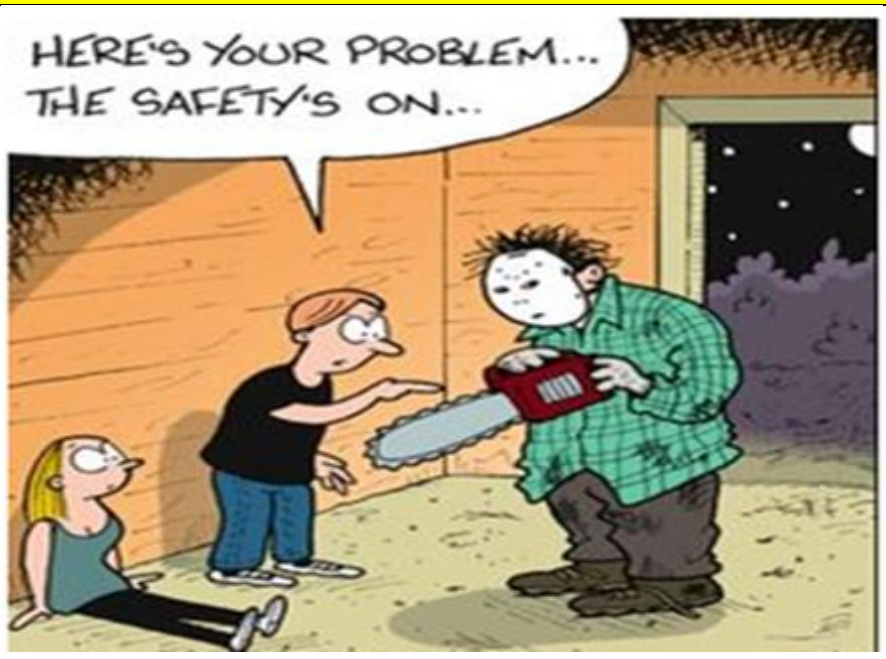
- It is a form of checking
- It provides short-term relief but keeps anxiety going in the medium and long-term
- It keeps focus on danger and increases doubt
- It increases rumination and dwelling on negative thoughts
- It undermines confidence in memory

Thought Suppression

- It provides short-term relief but keeps anxiety going in the medium and long-term
- It often does not work, as trying to suppress thoughts makes you have more of them
- It prevents you from accepting/ignoring/dismissing thoughts

Reflection:

Can you think of any common situation in which you might be likely to use any of these behaviours?



Anxiety, Obsessive-Compulsive Disorder and Subtypes of OCD

Let's see now more in details how Obsessions and Compulsions present in OCD:

Obsessions. When we use the word "obsession" in OCD we mean something different from its everyday meaning. In OCD an obsession is a persistent thought, image or urge that pops into your mind and causes distress.
Examples are usually related to the thing that the person fears most:

- *Causing harm to others (especially children)*
- *Having sex with people who are (or are perceived to be) inappropriate*
- *Saying or thinking things that contravene religious belief (blaspheming)*
- *Being contaminated*
- *Forgetting something important*

Sometimes people just have obsessions as the only symptom – we sometimes call this "Big O"

Compulsions. Compulsions are a particular type of **safety-seeking behaviours**: they are usually behaviours that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly:

- Repetitive behaviours (e.g. hand washing, ordering, checking)
- Mental acts (e.g. praying, counting, repeating words silently)

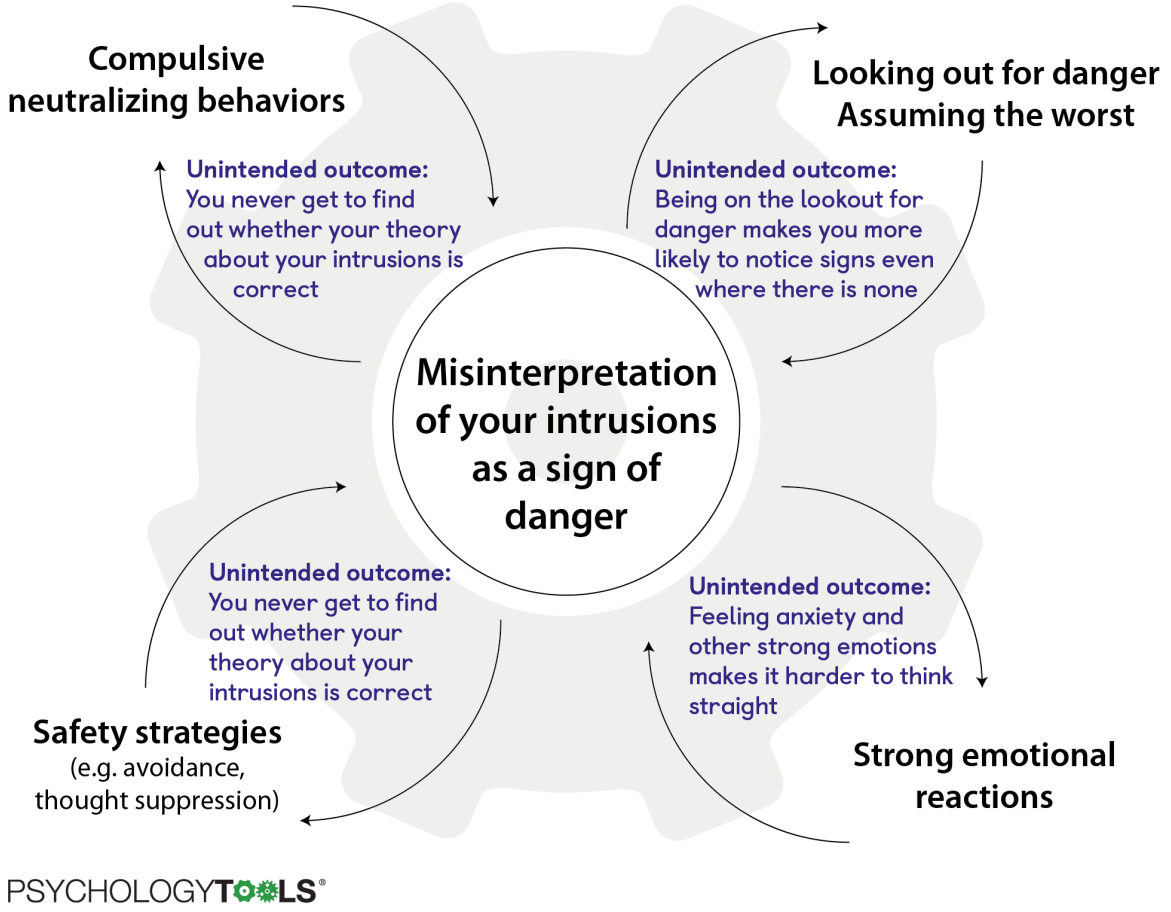
The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Compulsions are acts, that are repeated again and again, with the intention of reducing the perceived likelihood of harm. In effect they are trying to reduce the anxiety. The person with OCD will usually only stop doing the compulsion when they feel *just right*.

Some of the common compulsions in OCD are:

- *Checking*
- *Washing and cleaning*
- *Repeating*
- *Mental Rituals*
- *Ordering*
- *Hoarding*
- *Counting*

Safety-seeking behaviours and negative interpretations in OCD



PSYCHOLOGYTOOLS®

Involvement of family members and carers

OCD often involves activities of daily living, and therefore it can have a significant negative impact on relationships and on the family context.

Family symptom accommodation refers to changes in relatives' behaviour in order to prevent or reduce the person's distress related to their OCD symptoms or to reduce time spent in performing compulsions. Indeed, family members usually report that their efforts at accommodation are aimed at decreasing distress or time associated with OCD symptom and behaviours.

Examples include engaging in rituals on behalf of or with the patient (e.g. checking, cleaning, washing), providing supplies (e.g. buying cleaning products) or giving reassurance.

Accommodation can appear as an effective strategy in the short-term and OCD-affected individuals can even become upset or aggressive if family members or carers decline to provide accommodation. However, as it happens with safety-seeking behaviours, accommodating OCD symptoms prevents the person from confronting their obsessional thoughts (through continued engagement in compulsions) and keeps the distress in the long-term, creating another vicious cycle which involves others' accommodating responses and OCD symptoms.

As a matter of fact, scientific research shows that higher levels of family accommodation are associated with worse OCD symptoms, higher functional impairment and poorer treatment outcomes. Over time accommodation is also related to significant family member distress and family dysfunction.

Cognitive Behavioural Therapy for OCD is increasingly involving family members and carers into treatment, in order to provide information and develop a shared understanding of OCD, reduce unhelpful patterns of interaction and promote collaboration and am empowering team approach of the family.

Therefore, it can be a good idea to consider sharing information about OCD and about CBT treatment with family members, partners and carers, in order to share an understanding of the problem and of the potential consequences of safety-seeking behaviours in the medium and long-term, and in order to develop a collaborative approach in applying the CBT skills and techniques necessary to tackle OCD.

Goal setting.

Choose a goal that is possible to accomplish which will be helpful in obtaining some control over your OCD. It is critically important that the goal is behavioural and small.

Making goals "SMART"

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imely or time limited

Avoid making your goals vague such as *"I'll cut down on my washing", "I won't obsess this week"*. The problem with goals that are not SMART is that it may be difficult to realise when you have achieved this goal and monitor progress.

A SMART goal should identify - for example - at what times and under what circumstances will you not wash and for how long. Thus, an appropriate goal for washing might be:

- "*On Tuesday and Thursday this week between 2:30pm and 3:00pm I'll do my household chores without washing"* or

- "O*n Tuesday and Thursday, I will touch the rubbish bin, contaminate my kitchen, not wash for one half hour and leave it contaminated for the rest of the day*"

Being specific makes it easier for one to know when one has succeeded.

Some examples of goals might be:

For contamination problems:

1) Touching something contaminated in the meeting room and agreeing to spread it around the home

2) Touching a contaminated object with hands, touch food and then eating it

3) Put groceries away without washing them

4) Touching a contaminated object and contaminating a fellow group member

For checking problems:

1) Face away from the stove, turn it on, and turn the knob to the position that might be off and leave the house

2) Leave lights on or tap dripping

3) Read a newspaper article and black out the print with a magic marker while reading, so that checking is impossible

For "hit and run" fears:

1) Drive by a school when children are being let out and don't look in rear view mirror

2) After arriving home spend fifteen minutes saying to yourself, *"I'll never know if I hit anyone on the way home unless the police come for me, so I have to get used to this uncertainty".* Do this three times this week

For ordering:

1) Turn food cans in cabinet without labels facing front and out of size order

2) Purposely fold towels wrong and put them away this way

3) Arrange desk by knocking everything a little bit

Week 2 - Task 1:

Safety Seeking Behaviours (SBs) record:

Situation	Feelings	SBs	Short-term consequences	Potential long-term consequences
e.g. I am leaving the house to go on holidays.	*Anxious, nervous, scared.*	*I go back four times to check that I locked the door properly.*	*Relief, safe.*	*Being late for the flight. Arguing with my partner. Next time I will feel the need to check again.*

Week 2 - Task 2:

My GOALS - 'SMART'

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imely or time limited

1.	
2.	
3.	
4.	
5.	
6.	

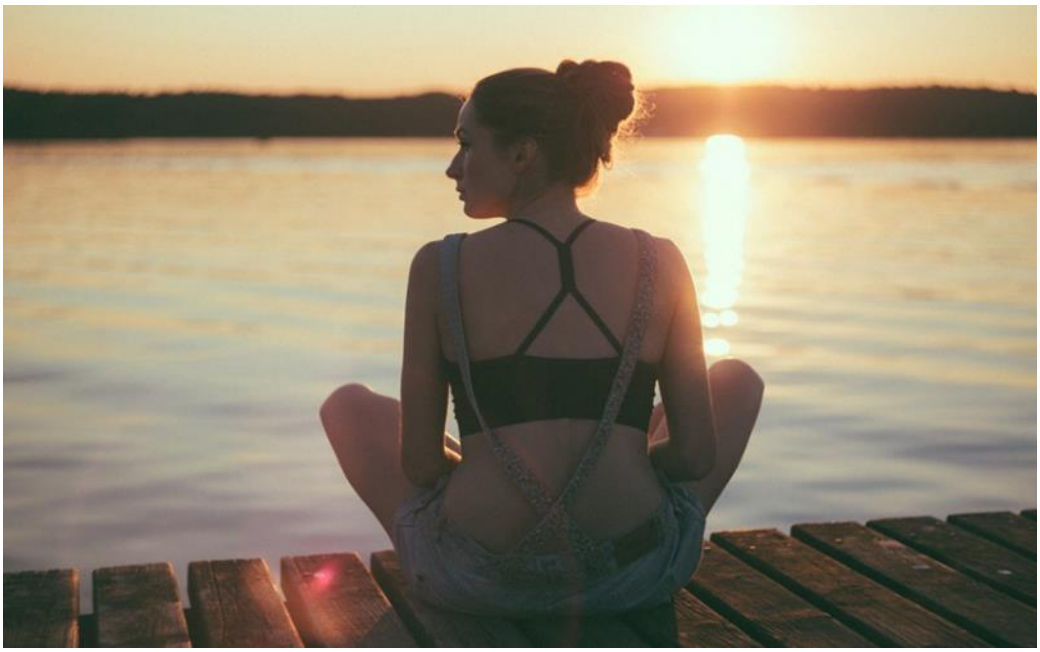
Week 3 – Anxiety & Relaxation Skills

In the coming weeks we are going to invite you to do things that break the patterns of your compulsions; or to sit with, or tolerate your obsessions without trying to get rid of them.

This is inevitably going to make you anxious, so before we start to think about those exercises it is important to identify what we mean by relaxation skills.

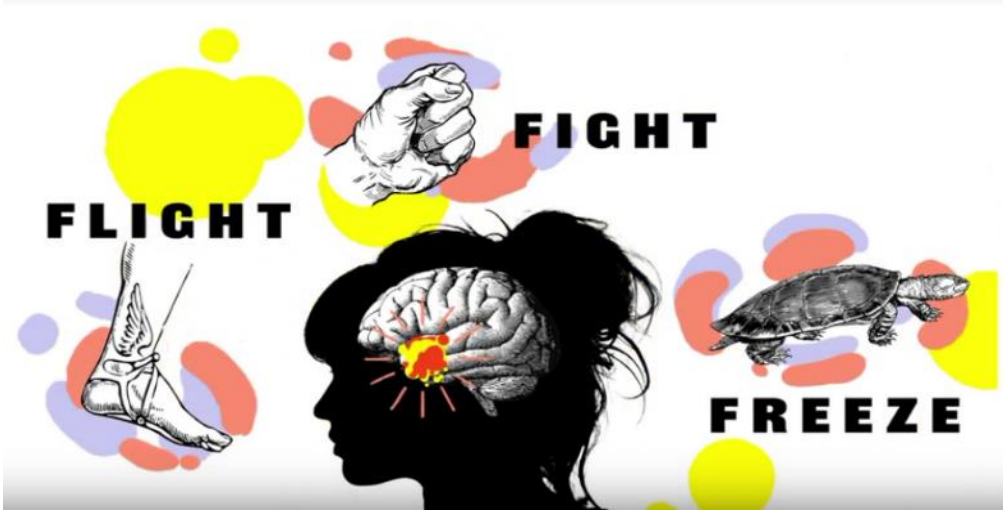
So, the first question is how do you relax at the moment? How effective is this? List some ideas of how you usually try to relax – this can be helpful to share with the other members of the group and with the facilitators too:

How can we make relaxation more effective?



In order to answer this question, we need next to look at how the body responds to anxiety.

The Fight, Flight, Freeze Response.



When we were evolving and adapting as early humans, the threats we faced were very immediate and very real. We needed to be able to respond quickly and effectively in order to survive and reproduce, so we have inherited the brain mechanism that the “survivors” had: the **Fight, Flight, Freeze** response.

Our emotions have a purpose. Our most basic emotions like fear, anger or disgust are vital messengers: they evolved as signals to help us meet our basic needs for self-preservation and safety.

Imagine you face such a threat:

What do you want to do?

The **Fight, Flight, Freeze** response is a physiological reaction that occurs in response to a perceived harmful event, attack, or threat. So, it is important to think of this as a normal response, a body alarm system which can be triggered too often, by things which we perceive to be a threat to us.

Why can **fighting** be a helpful response to a threatening situation? Fighting comes with risks of injury, death, or other consequences, but winning increases our chances of survival. Sometimes looking aggressive can be enough to make an opponent back down.

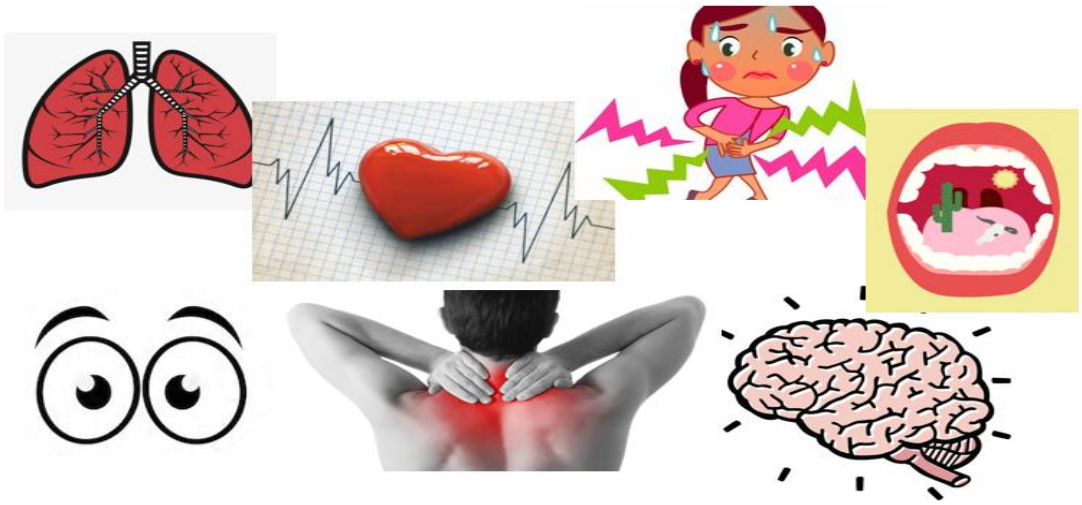
Why is it helpful to escape - **flight** - from a threatening situation? A successful escape can mean survival, often with fewer costs than other options.

Freezing is a reaction to specific stimuli, most commonly observed in prey animals to escape by feigning death so that the predator stops the attack. It gives us time to evaluate a situation, makes us less noticeable. If it is not possible to escape or fight - or if the anxiety becomes too overwhelming - then becoming unresponsive might be the best chance for survival. This might be experienced as feeling paralyzed by the overwhelming anxiety or fear.

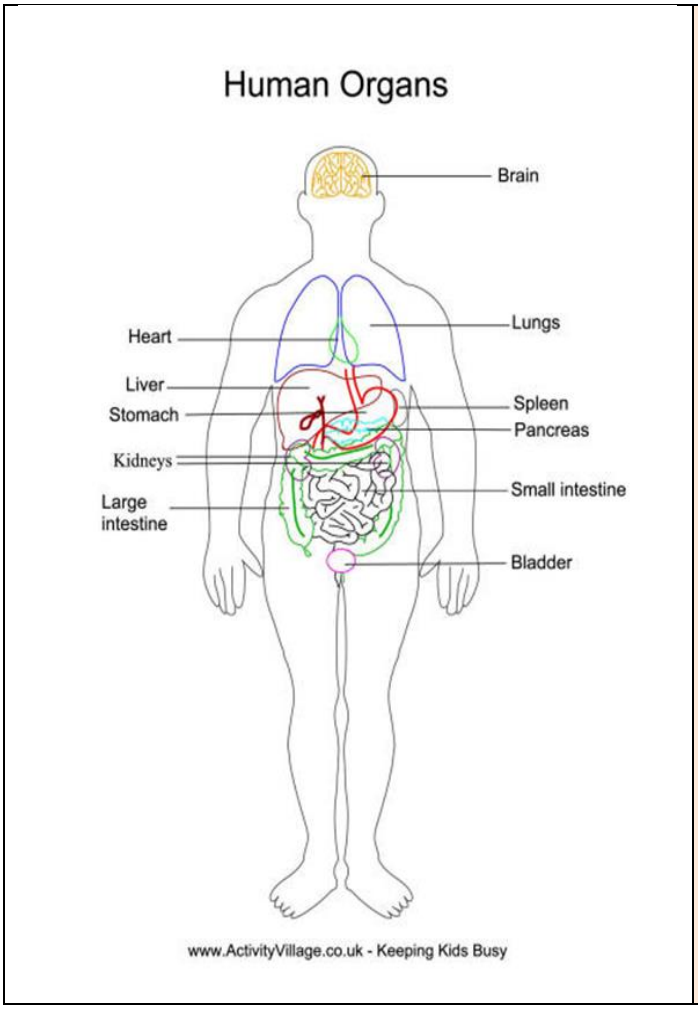
A good analogy for the Fight, Flight, Freeze reaction is the smoke alarm. A smoke alarm is designed to alert us to the danger of fire but it cannot distinguish between steam from the shower, a burnt toast or a house fire. While the first two examples are not real threats, the third is but the response of the alarm is the same: an irritating, uncomfortable and difficult to ignore sound!

The Fight, Flight, Freeze response was designed to deal with feeling fear for our lives, but it is much more likely to be triggered by more complex and subtle concerns: for example, internal threats in the form of appraisal of embarrassment in social situations. When we feel anxious or fearful about a presentation, job interview, exam, or meeting new people the Fight, Flight, Freeze response is triggered in our body and we experience a range of strong, physical symptoms designed to temporarily change the way the body is functioning to enable rapid physical response.

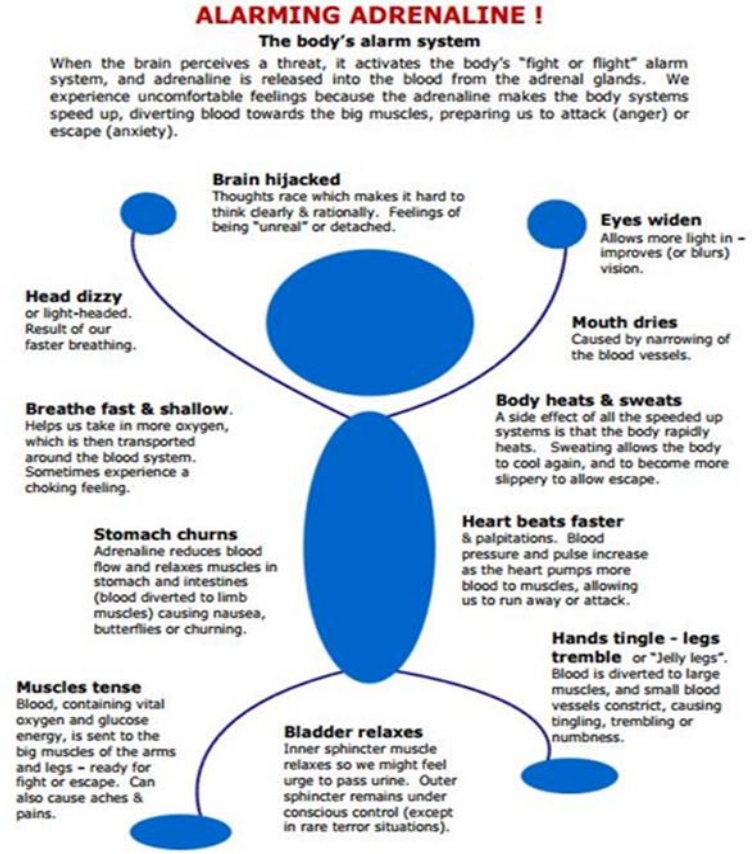
How the body responds to anxiety



The way the body works is its physiology. Using the chart below as a prompt, list all the possible ways that the body's physiology changes when the brain experiences anxiety. Try to also think about your own experience of anxiety, and what happens in your body when you feel anxious:



These are usually the most common physical changes and sensations associated with anxiety – and with the Fight, Flight, Freeze response:



○ This whole process is initiated by the release of a hormone called adrenaline from the adrenal glands ○ Rate of breathing increases, so oxygen levels in the blood increase ○ Heart rate increases, the heart beats harder, and blood pressure increases ○ Blood flow is diverted from the core (digestive organs) to the periphery (limbs, skin) ○ Blood vessels near the skin relax, increasing blood flow moving to the surface, leads to feeling flushed or hot (& blushing), this in turn leads to sweating, resulting in dampness and rapid cooling, so there may be alternating hot and cold ○ Digestive system is slowed or switched off ○ Immune response decreases	○ Reduced blood flow to salivary glands leads to dry mouth ○ Rapid "Mexican wave" contractions in digestive system can lead to churning stomach or butterflies ○ All skeletal muscles tense up, which can lead to tremors or shaking; neck, shoulder or chest pain ○ Pupils dilate (to increase peripheral vision) but leading to a loss of focus, i.e. blurred vision ○ Brain function changes, we become more instinctive and less rational or cognitive ○ Liver releases extra sugar for energy, but has to cope with reduced blood flow ○ Increased desire to pee or poo as the body tries to "lighten the load" ○ Sexual response inhibited

Check this video: https://www.youtube.com/watch?v=jEHwB1PG_-Q

Using an understanding of the Fight, Flight, Freeze mechanism

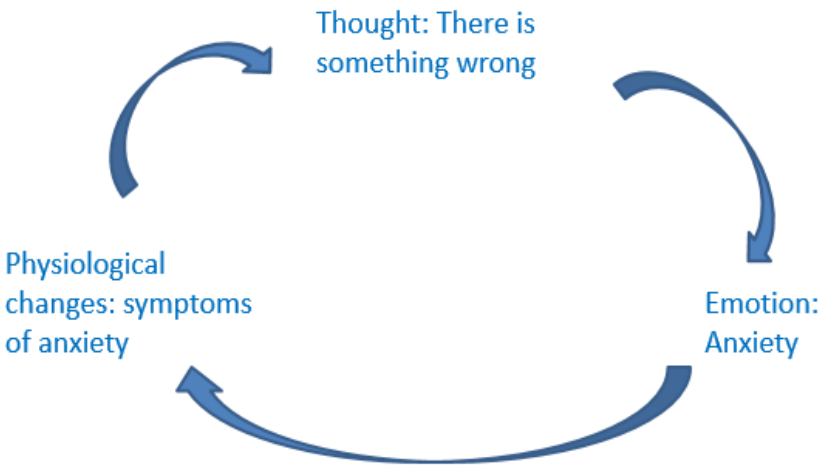
You might be wondering how understanding the physical symptoms of the Fight, Flight, Freeze response is going to help you feel less anxious.

The physiological changes or symptoms of anxiety can be very uncomfortable, like pain, and can lead us to conclude something is really wrong, a thought which increases our anxiety. So, anxiety can persist because we have both an emotional and a cognitive reaction to our anxiety which keeps anxiety going. We get anxious about getting anxious or experience fear of fear.

This is even more likely if there is not an obvious source of physical danger in the vicinity which we can choose to combat or escape from. Then, when we can't see an external danger, we tend to use our powerful imagination to search for the source of anxiety. In this way we start responding to perceived dangers with a **thought**:

"I might make a fool of myself in the presentation" or *"I might fail the exam"*

We thereby create a reason to be anxious which, along with our physical symptoms, then proves to us that we should be anxious.



The first step to breaking the cycle is to recognise the symptoms of anxiety, and to remind ourselves that they are not evidence of something being really wrong: they are not in themselves a reason to become more anxious, but just our Fight, Flight, Freeze system at work.

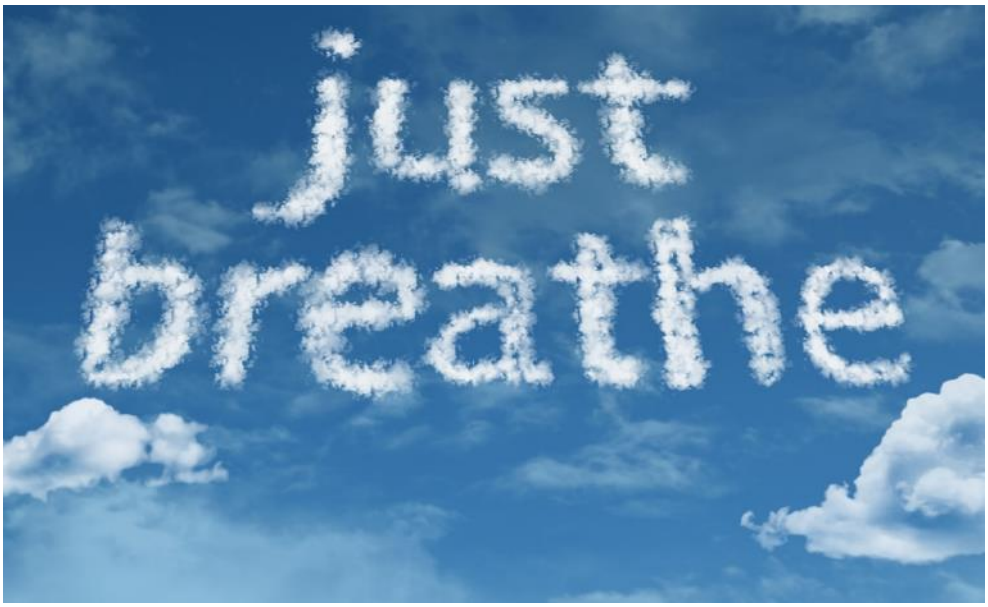
10 Statements for Confronting Anxiety

- Anxiety is NORMAL and TEMPORARY
- Anxious sensations feel uncomfortable - but they are NOT dangerous
- Anxiety will NOT hurt me. It's just my flight or fight/adrenalin system at work
- I have to make myself anxious to get better - If I stop now, I'll only be making it worse
- It is worth being anxious in the short term to get over this in the long term
- When I have faced my fears before - I've always eventually felt better
- Trying to control anxiety does NOT work
- I need to go with anxiety to get better
- The trigger only bothers me because I give it so much negative meaning
- I CAN handle this - I CAN let the anxiety decrease by itself

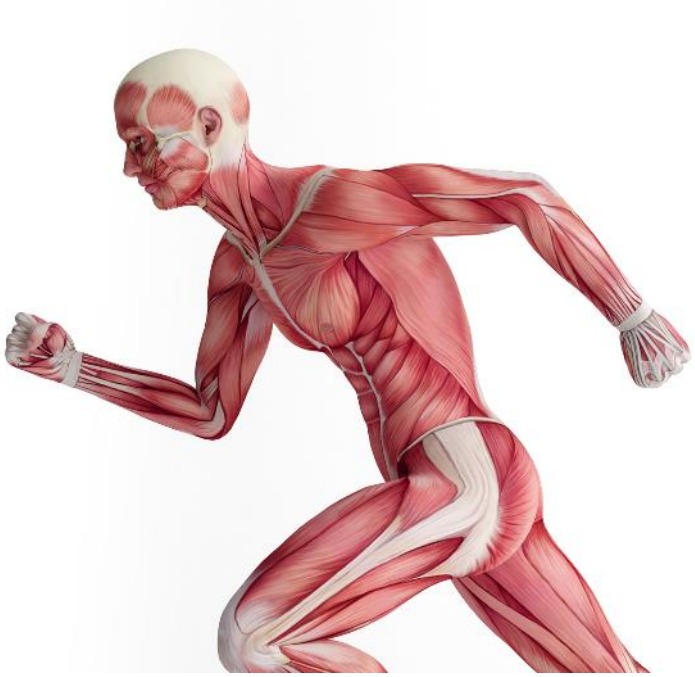
The next step can then be to deal with the physical symptoms of anxiety as symptoms which can be "treated". Of all the physical symptoms that we have described earlier, which ones do you think are the ones we can control more?

The two main anxiety symptoms that are under conscious control are:

1) Breathing



2) Muscle tension



Learning to calm down your rapid breathing and learning to relax your tense muscles can counteract the Fight, Flight, Freeze response and help to bring on its counter-balance: **Rest And Digest – The Relaxation Response**.

Two counter-balanced systems

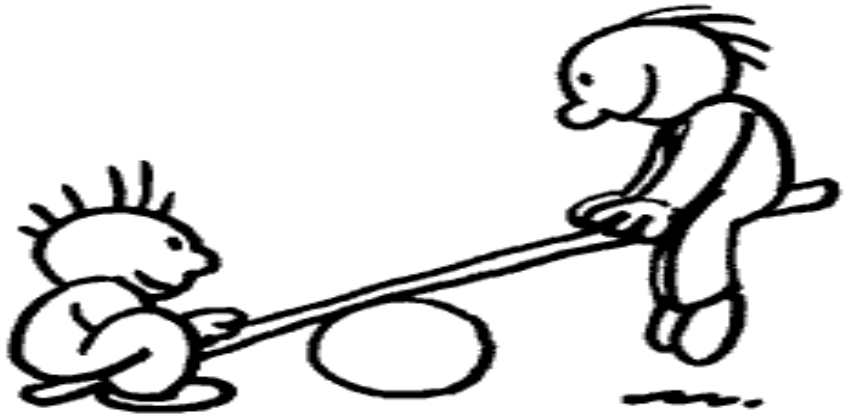
It's not simply a matter of the Fight, Flight, Freeze system being "on" or "off".

The body has two counter balanced systems, each with their own physical pathways and neurotransmitters.

Just as the Fight, Flight, Freeze response is the response to anxiety, so there is a Rest and Digest system (sometimes called the "breed and feed"), which is linked to a relaxed emotional state. By and large the Rest and Digest system simply does the opposite of the Fight, Flight, Freeze:

- Activating normal digestion
- Relaxing the sphincters in the digestive tract
- Slowing heart rate
- Slower breathing
- Relaxed muscles

As one comes on, so the other goes off, and vice versa. It works rather like a see-saw:



This means that if we can change some elements of the body's Fight, Flight, Freeze response - e.g. the breathing and muscle tension - to the relaxed state, then we can help shift from an anxious emotional state to a more relaxed state.

Learning the skills of relaxation is also an important resource in helping you to tackle your symptoms of OCD and manage with exposing yourself to your fears – as we will learn to do and practise during our next sessions.

Week 3 - Task 1: Practising relaxation - Breathing

Normally each in breath, and each out breath, when at rest will take about 2 seconds, the breathing 'cycle' therefore takes about 4 seconds. When we get anxious that rate can increase to 1 second. This will feel tense and uncomfortable. The body will compensate for the increased rate of breathing by making each breath shallower.
In order to relax we need to not only return to the "ordinary" rate, but to go further, to ""over learn". There are several models of breathing for relaxation. Practise each of them – or look for different ones – and pick one that you feel it is more helpful for you and effective in bringing you to a relaxed state.

'5 seconds in; 7 seconds out'

Getting ready for action means breathing in more than you breath out, because we need more oxygen (e.g. in our muscles) to face the threat. Therefore, in order to relax, all you have to do to switch off is the opposite.

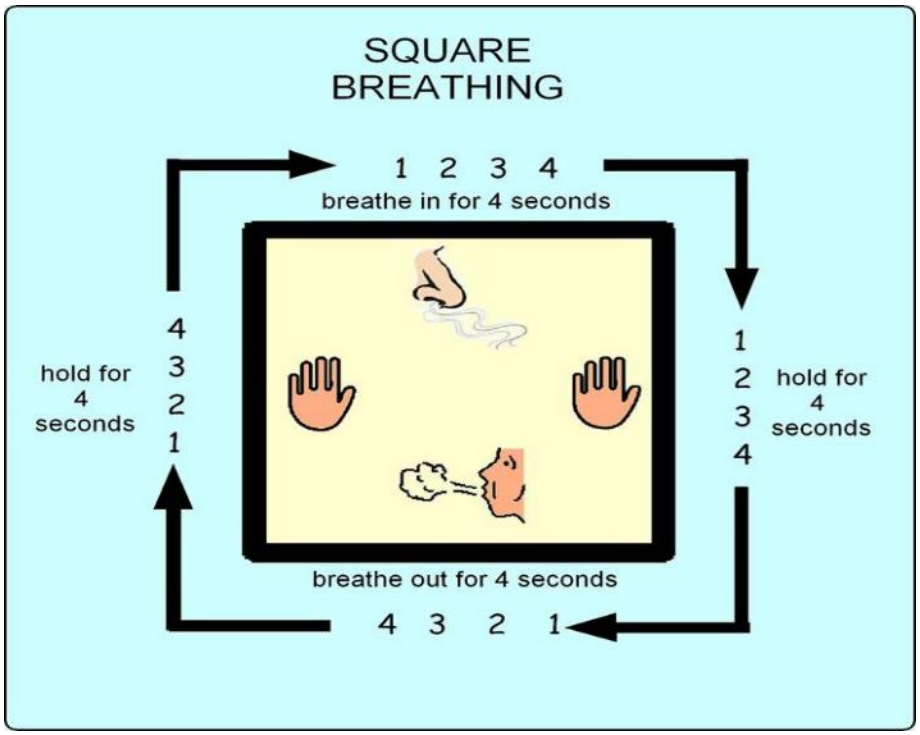
I… n… / O… u… t… …
(out twice as long as in)

Practice this regularly, starting when you are relaxed and then when you have a moment of intense emotional distress. You naturally relax your chest muscles when breathing out.
This is a breathing cycle of 12 seconds. Give it a try, many people find it very relaxing. Which part of the cycle gives you the greatest sense of relaxation? Many people say that it is the last part of the out breath which gives the best sense of relaxation.

Diaphragmatic Breathing

Put one hand on your belly just below your ribs and the other hand on your chest. Take a deep breath in through your nose, and let your belly push your hand out. Your chest should not move. Your belly should come outward as you take in air, and you'll feel your lungs opening up. This draws oxygen all the way down into the bottom of your lungs. As you exhale, your stomach will come back in, and your rib cage will contract. This uses the diaphragm muscle to make sure you get the optimal amount of air.

Square Breathing



Week 3 - Task 2: Practising relaxation - Progressive Muscle Relaxation

You can use a video from the web, like this one:

https://www.youtube.com/watch?v=ihO02wUzgkc

Or the following script:

Progressive muscle relaxation is an exercise that reduces stress and anxiety in your body by having you slowly tense and then relax each muscle. This exercise can provide an immediate feeling of relaxation, but it's best to practice frequently. With experience, you will become more aware of when you are experiencing tension and you will have the skills to help you relax. During this exercise, each muscle should be tensed, but not to the point of strain. If you have any injuries or pain, you can skip the affected areas. Pay special attention to the feeling of releasing tension in each muscle and the resulting feeling of relaxation. Let's begin.

Sit back or lie down in a comfortable position. Shut your eyes if you're comfortable doing so.

Begin by taking a deep breath and noticing the feeling of air filling your lungs.

Hold your breath for a few seconds.

(brief pause)

Release the breath slowly and let the tension leave your body.

Take in another deep breath and hold it.

(brief pause)

Again, slowly release the air.

Even slower now, take another breath. Fill your lungs and hold the air.

(brief pause)

Slowly release the breath and imagine the feeling of tension leaving your body.

Now, move your attention to your feet. Begin to tense your feet by curling your toes and the arch of your foot. Hold onto the tension and notice what it feels like.

(5 second pause)

Release the tension in your foot. Notice the new feeling of relaxation.

Next, begin to focus on your lower leg. Tense the muscles in your calves. Hold them tightly and pay attention to the feeling of tension.

(5 second pause)

Release the tension from your lower legs. Again, notice the feeling of relaxation. Remember to continue taking deep breaths.

Next, tense the muscles of your upper leg and pelvis. You can do this by tightly squeezing your thighs together. Make sure you feel tenseness without going to the point of strain.

(5 second pause)

And release. Feel the tension leave your muscles.

Begin to tense your stomach and chest. You can do this by sucking your stomach in. Squeeze harder and hold the tension. A little bit longer.

(5 second pause)

Release the tension. Allow your body to go limp. Let yourself notice the feeling of relaxation.

Continue taking deep breaths. Breathe in slowly, noticing the air fill your lungs, and hold it.

(brief pause)

Release the air slowly. Feel it leaving your lungs.

Next, tense the muscles in your back by bringing your shoulders together behind you. Hold them tightly. Tense them as hard as you can without straining and keep holding.

(5 second pause)

Release the tension from your back. Feel the tension slowly leaving your body, and the new feeling of relaxation. Notice how different your body feels when you allow it to relax.

Tense your arms all the way from your hands to your shoulders. Make a fist and squeeze all the way up your arm. Hold it.

(5 second pause)

Release the tension from your arms and shoulders. Notice the feeling of relaxation in your fingers, hands, arms, and shoulders. Notice how your arms feel limp and at ease.

Move up to your neck and your head. Tense your face and your neck by distorting the muscles around your eyes and mouth.

(5 second pause)

Release the tension. Again, notice the new feeling of relaxation.

Finally, tense your entire body. Tense your feet, legs, stomach, chest, arms, head, and neck.

Tense harder, without straining. Hold the tension.

(5 second pause)

Now release. Allow your whole body to go limp. Pay attention to the feeling of relaxation, and how different it is from the feeling of tension.

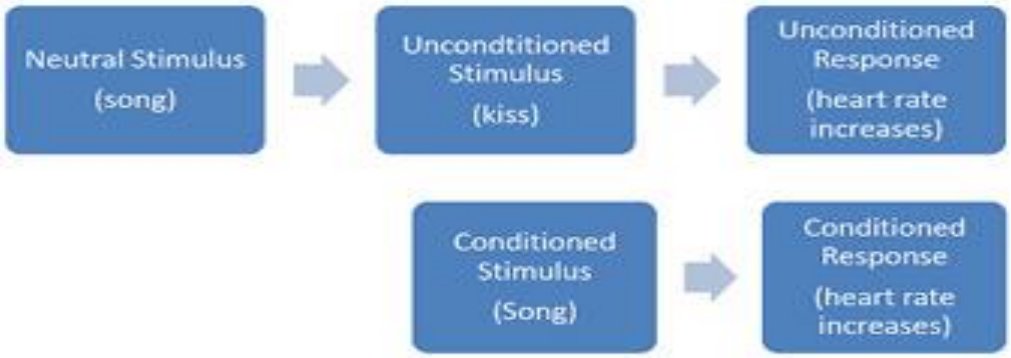
Begin to wake your body up by slowly moving your muscles. Adjust your arms and legs.

Stretch your muscles and open your eyes when you're ready.

Week 4 – Exposure and Response Prevention (part 1)

In Cognitive-Behavioural Therapy, the idea is that behaviour is learned through building associations and/or through the consequences of the behaviour. Therefore, we can change the behaviour by breaking associations and/or changing consequences.

- Learning by association - It refers to learning that occurs when a neutral stimulus (e.g. a song) becomes associated with a stimulus (e.g. a kiss) that naturally produces a behavior (e.g. heart rate increase). After the association is learned, the previously neutral stimulus (the song) is sufficient to produce the behavior (the heart rate increase):



Now, ask yourself: what happens if you listen to the same song over and over again?

- Learning by consequence - This occurs when an association is made between a behavior and a consequence (whether negative or positive) for that behavior:

Now, ask yourself: what happens if the consequence is a short-term relief and the behaviour is not helpful in the long-term (safety-seeking behaviour)?

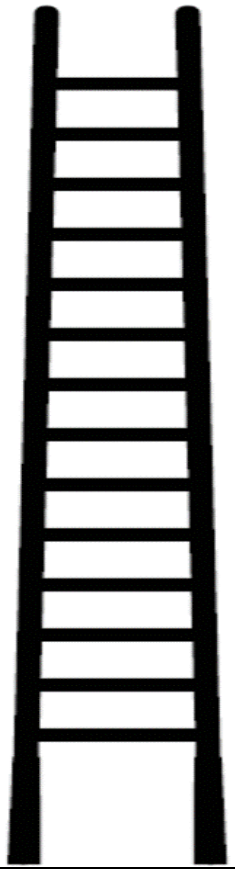
Exposure is the idea that, if we sit with the object or situation that trigger our anxiety, in time the anxiety will diminish. The idea is that repeated exposure is accompanied by learning of new associations about the stimulus (the object or situation that trigger our fear), which in time weakens the previous association stimulus-fear.

How can we begin to bring about change, and help someone with an anxiety problem?

Let's start by thinking about the person who is scared of dogs.

One way to start would be to get that person to start ranking their most feared dog encounter through to their least feared dog encounter. We could do this on a 10-point scale, rather like a ladder with ten rungs on it. It is important to try to make a prediction of the level of distress that we might experience in a particular situation. This is usually measured in "Subjective Units of Distress" (SUDs), which means a scale of 0 to 10 for measuring the subjective intensity of disturbance or distress currently experienced by an individual.

Example - *Max is scared of dogs, and she came up with the following list:*



10: Taking something out of a dog's mouth – **SUDs 9.9**

9: Touching a dog – **SUDs 9.0**

8: Sitting very close to a dog – **SUDs 8.5**

7: Sitting in the same room as a dog – **SUDs 8.3**

6: A loud dog in the park a long way off, but barking and jumping around – **SUDs 8.0**

5: A small quiet dog off a lead, in the distance, say in the far corner of the park, with its owner nearby – **SUDs 7.5**

4: A large dog on a lead, in the park – **SUDs 6.0**

3: A very small dog on a lead in the park, a long way off – **SUDs 5.0**

2: A film about a dog – **SUDs 4.5**

1: Photos of big dogs – **SUDs 3.5**

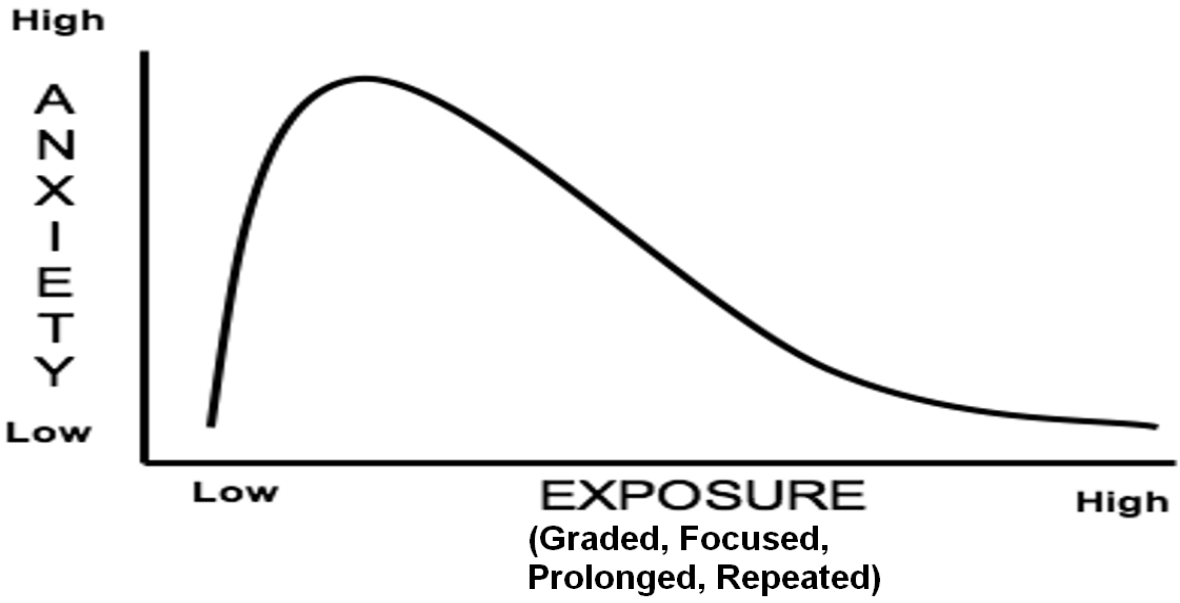
This is Max's ladder of feared situations. The technical name for this is a "hierarchy of exposure".

The principle of exposure is to get used to the trigger at each step, before proceeding to the next step.

Now, try to imagine a similar fear or phobia and try to write down an example of hierarchy of exposure (not about you, try to imagine one – e.g. fear of another animal, fear of a particular place or situation, etc.). Remember to score the predicted SUDs and that it is important to start with something at the lower end of your hierarchy – a situation which challenges you a bit, but not too much.

		SUDs - 0-10
		

The way through which exposure works is by developing “habituation”. Habituation is a form of learning in which a response to a stimulus (object or situation) decreases after presentations of that stimulus:



During an exposure task, usually the anxiety or distress initially increases, before a person starts to develop habituation. In order to develop habituation to a feared object or situation, when working with exposure we need to meet 4 important criteria. Exposure needs to be:

Graded. Exposure needs to follow a hierarchy of situation, in which the individual starts from the bottom and gradually complete the hierarchy by undertaking harder tasks. Ideally, a person should start from a level of SUDs which is not too high but not even too low, usually between 3-4.
Focused. The individual needs to stay with the anxiety and avoid distractions and safety-seeking behaviours, unless inevitable. In this case, the person can gradually drop safety-seeking behaviours.
Prolonged. The person needs to be in a situation of exposure for long enough to allow themselves to develop habituation. This does not mean that SUDs need to get to 0, but ideally to a level of distress which is perceived as easily manageable.
Repeated. The person needs to practise exposure tasks as frequent as possible, ideally every day – even several times a day. The more repeated, the more likely and effective exposure will be.

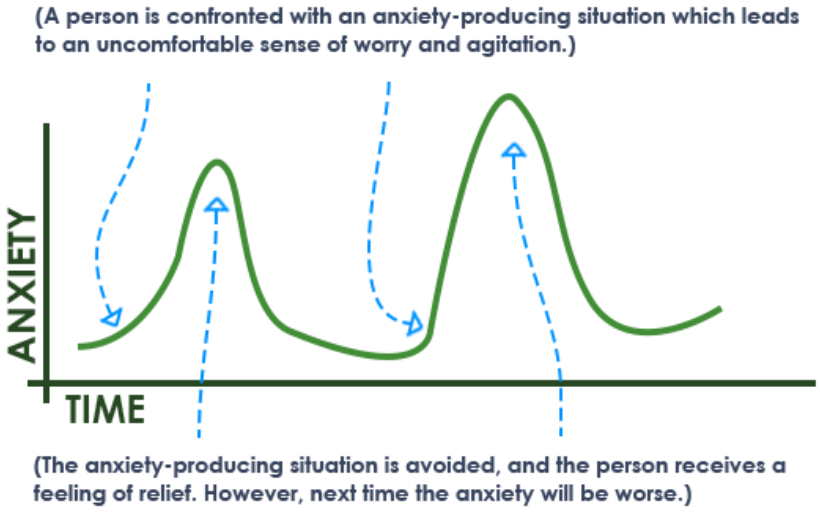
It is important to sit with that trigger for long enough for the anxiety to diminish of its own accord.

Exposure for OCD is called **Exposure and Response Prevention (ERP)**. OCD is maintained because the person responds to the trigger – and consequent anxiety – with a safety-seeking or neutralising behaviour that quickly kicks in. This leads to a dysfunctional assumption:

"*I only got through that because of what I did*"

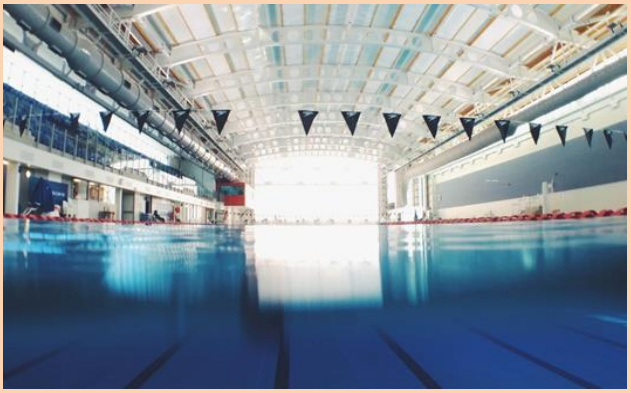
e.g. "*I only managed to use that public toilet, without catching a terrible disease, because I washed my hands three times afterwards*"; "*I only managed not to harm anyone because I sang that song in my head twice*"; etc.

A funny story of safety-seeking behaviours and dragons	
A girl walked out on a balcony and saw a friend looking at the sky and waving his arms. When she asked what he was doing, he replied: "*I am waving my arms to scare the dragons away"* She was surprised to hear that answer, so she made him notice: "*But look, there are no dragons!*" He looked and replied back: "*Well, it means that my behaviour is working*"	



Exposure and Response Prevention is a therapy that encourages you to face your fears and let obsessive thoughts occur without "putting them right" or "neutralising" them with compulsions.

ERP. Exposure means facing your fears in a prolonged period of contact. Response Prevention means not responding to your urges to ritualise or use one of your safety seeking behaviours.
The process of exposure and response prevention, and the gradual reduction in anxiety that follows is called habituation: basically, gradually getting used to it – making it into a habit. E.g. when we get into the water in a swimming pool it feels very cold; however, after a few minutes we have got used to it.



For example:

- *For someone with contamination fears it might mean touching the floor and not washing*
- *For someone with intrusive obsessions it might mean sitting with their thoughts that they are a sexual predator or paedophile, while playing with children*
- *For someone with obsessive thoughts about the safety of their house, it might be going to sleep without checking the oven or the taps*

It's important to resist both the desire to perform rituals and safety seeking behaviours. ERP is usually more effective when done as part of a planned programme of deliberate exposure.
It's important to first work on stopping (or gradually reducing) the rituals, as the exposure will be of little or no value, if it is then followed by the neutralising ritual.

Check this video: https://www.youtube.com/watch?v=jYRlAW9KdBI

Mini rituals

It's important to be on the lookout for "mini rituals" as well as the more obvious ones. These might include giving dishes a quick rinse under the tap; or a quick wipe with a cloth; or glancing back at a lock to make sure it looks alright. It's really important to gradually eliminate all rituals to help prevent the OCD returning.

One particular form of safety seeking behaviour is reassurance-seeking, sometimes called the reassurance seeking-reassurance provision cycle: "*Is this clean enough?", "Did I lock that door?"*.

Sometimes it might be helpful to include other people in ERP work. For example, if you check with others about aspects of your rituals, and probably to be helpful they answer affirmatively, you could think together about alternative ways for them to respond, e.g.: *"What do you think?".*

A key motto to remember is:

"The compulsion is only managing the anxiety not the risk"

"**Pure obsessions**". Sometimes people struggling with OCD experience obsessions as they only symptom – we sometimes call this "**Big O**".

If you feel that your main issue is not about compulsions, rituals or repetitive behaviours, but mainly about intrusive thoughts and obsessions, you can still work with exposure.

You can develop a hierarchy of distressing thoughts, proceeding gradually from easiest to hardest, and practise exposure in the same way as you would do with ERP: write distressing thought down and rate SUDs, until SUDs go down to 20-30% - then write another one proceeding through the hierarchy.

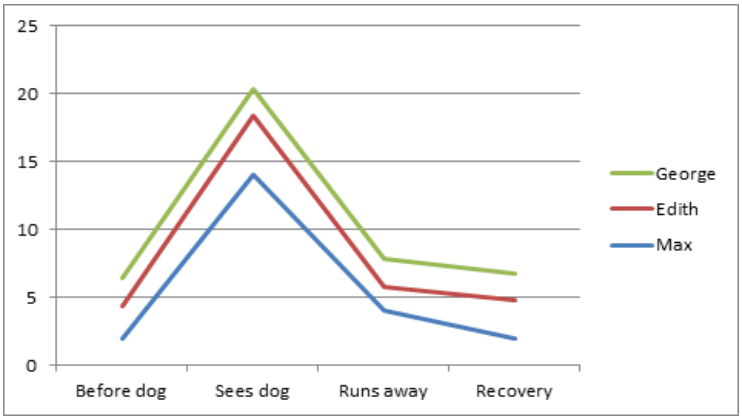
Check this video: https://www.youtube.com/watch?v=Q7LWUB-GXFg

Now, try to think about example of exposure tasks in ERP and exposure for OCD:

e.g. ▪ *going to bed at night without checking any tap in the house* ▪ *locking the door and leaving the building without going back and checking it*

Let's think about the fear of dog example again. Each time Max sees (or even hears) a dog, she thinks the dog is going to attack her. She becomes very scared (i.e. she has a "spike" of anxiety) and she immediately runs away, and the anxiety subsides.

Here we have measured the anxiety of three people who are scared of dogs.



Who is most scared of dogs? What will happen when they next see a dog?

Trigger	**Thought**	**Behaviour**	**Short-term Consequences**	**Long-term Consequences**
Dog	The dog will attack me	Avoidance	Relief	No chance to disconfirm the negative prediction No chance to develop habituation Fear of dog is maintained or even worsened

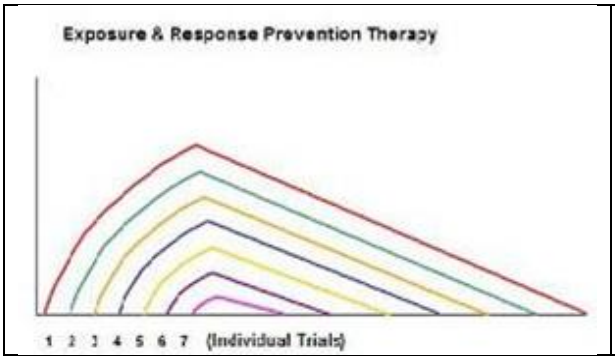
Let's assume that Max has done some work with their therapist and is now sitting with a dog. We are going to ask her to spend a session sitting with a dog.

She is getting really anxious on the way to the room.

She's on maximum anxiety when she sees the dog.

But the dog just sits quietly in the corner.

After a while it curls up in its basket. Little by little Max relaxes. Look at the graph of what happened to her anxiety below. What do the lines 1, 2, 3, etc. represent here?



Now you can create your own hierarchy of fears.

This hierarchy (or ladder) of fears will be an important tool for you to plan your own therapy. If you keep ticking off when you feel that you have achieved each step (i.e. that you can cope with that situation with SUDs of 2-3/10 – or 20-30% - or less), you will then know what challenge you face next.

What is important is that at each step you spend time acclimatising and getting used to that situation or environment.

First identify the situation that you feel most uncomfortable with (this may be your goal situation); label this as step 10. Then think about situations with which you are completely comfortable - these may be for example touching the carpet in your own bedroom - and label this at the "0" point. Then try to identify at least 5 intermediate situations between these two extremes.

Remember to score each situation with the SUDs/anxiety it currently causes you, out of 10 or as a %.

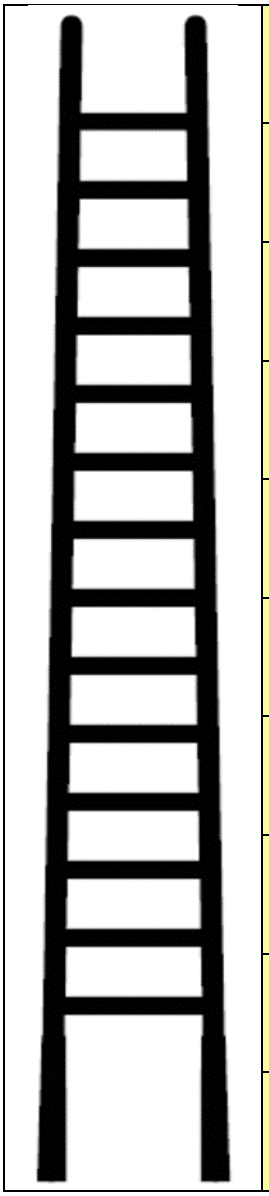
Once you have your hierarchy, it will be important to plan every task and take track of the level of SUDs or anxiety by monitoring it during the task. Look at the example below:

Situation	**Day/Time**	**SUDs** Before	**SUDs** Beginning	**SUDs** Peak	**SUDs** End	**SUDs** After	**Comments**
Leaving the house and checking the door just once, for max 5 seconds	*Monday at 8:30am*	***6.5***	***8.5***	***9***	***7.5***	***5.5***	*The anxiety started to decrease when I was in the car, and I stopped feeling worried about it when I arrived at the office*

Remember: you need to repeat a task until your SUDs go down to 2-3/10 or 20-30%, before you can move to the next task!

Week 4 – Task 1: Hierarchy of Exposure:

Following the guidelines above, develop your own hierarchy of exposure. Remember to score the SUDs and to consider using your main therapy goal as the top situation on the ladder.

		SUDs - 0-10
	**Your Goal:**	

Look at the hierarchy of fears that you have created. Think about where you are right now. Then think about what is the next practical step up the ladder, and think about what it would be like to go there. For example if your step 10 goal is to be able to use a public toilet, but at the moment you are at the point where you are only comfortable with using the toilet in your own home, or that of your immediate family (step 1), then think about what step 2 might look like. You might, for example, visit a friend who you know less well for the evening, and use their toilet.

Week 4 – Task 2: working with exposure:

Using the hierarchy of exposure that you have developed above, experiment with going up your ladder one step, and then recording what happens. Monitor your anxiety/SUDs using the following worksheet (as shown in the example above).

Remember to repeat the task until you feel that you have become comfortable with that particular situation. If habituation does not kick in and you keep feeling highly distressed or anxious, it might be worth considering re-planning the task by changing some elements of the situation in order to make it easier.

Situation	**Day/ Time**	**SUDs** Before	**SUDs** Beginning	**SUDs** Peak	**SUDs** End	**SUDs** After	**Comments**

Week 5 – Exposure and Response Prevention (part 2)

Imaginal exposure.

Sometimes it's not practical to repeat exposure frequently enough or for long enough. Sometimes it might feel overwhelming to tackle an experiment in exposure in the real world. In these cases, we can use the power of imagery.

You can purposefully think uncomfortable, fear provoking thoughts and hold these in your mind until you become habituated and your distress diminishes.

Imagery can have a very powerful effect on the body.

Listen to the following script and see – and write down - what effect it has on your emotions and body.

- *Imagine you're in a Sicilian lemon grove*
- *You can see the trees in front of you, their green leaves glistening*
- *The abundant bright yellow fruit hang from the branches*
- *You can feel the warm sun on your face*
- *And the red earth is sticky on your shoes*
- *You reach up and pick a lemon*
- *It is still warm from the sun. Feel the knobbly skin, and the weight of the fruit in your hand*
- *Now imagine that the fruit is split in half, the segments glistening with the fresh sharp juice*
- *You anticipate the intense lemon flavour*
- *Intrigued you tip your head back, and squeeze a few drops of the juice on your tongue, and taste the delicious, sweet, but intensely sharp juice*

Effects on my emotions and body

Sometimes people cannot actually put themselves into their feared situation, such as pouring hot coffee over another person. A mental visualization of this situation in detail will evoke fears of harming someone, which will offer exposure practice.

When working with imaginal exposure, all the principles and guidelines highlighted and used in our previous session are the same: we need a hierarchy of exposure and we need to monitor our anxiety/SUDs and observe if habituation is developed.

One way of doing this is using an **imaginal exposure script**.

This is a helpful tool for managing hypothetical worries and intrusive thoughts that you have little or no control over. This might include: thoughts about you or a loved one being in an accident, getting injured, catching a dangerous disease, harming someone, etc.

It can take a lot of time and energy to keep trying to avoid or neutralize these thoughts. The alternative is facing thoughts by writing down your core fears as a “imaginal exposure script”. The technique is similar to a journal or diary entry. Just like with behavioural avoidance this means that we will feel more anxious in the shorter term, but in the longer term we will habituate to the thought and it will lose its power over us.

Your imaginal exposure script should be frightening but realistic at the same time. The script needs to be vivid, meaning that we should include the five senses as much as possible (touch, taste, sight, smell, hearing) as well as your feelings and reactions. We should write it in the first person as if it is happening here and now. Try not to “soften” it as it can reduce the effectiveness.

This is an example from a woman suffering with OCD who is worrying that, if she did not perform certain preventing rituals, her son might be involved in a coach accident while on a school trip. She has become terribly worried about this, and she has been feeling compelled to perform counting rituals to prevent this terrible event from happening.
By working with an imaginal exposure script, she will need to keep her account realistic and with no easy way out of the situation:

"This morning I was late for work and I did not perform any of the rituals I usually do in the morning to keep myself and my family safe. I am feeling very anxious about this, I fear that something bad might happen.

I get a phone call to say that Johnny's school coach has been in a head-on collision. My mobile rings at work and I take the call, where the officer tells me in a stern voice that there has been an accident and I should come to the scene.

When I get there, I see Johnny's limp body just lying on the road, surrounded by broken glass and blood. I smell diesel and the fire brigade are spraying foam, to avoid an explosion. The paramedic checks Johnny. There's a pulse, but it's weak. Johnny is put in an ambulance. I ride along with him to the hospital. On the way, he stops breathing. I watch helplessly as the paramedic tries to resuscitate him. Finally, I hear a gasp, Johnny is breathing again.

I arrive at the hospital and am met by a trauma team. They rush Johnny to the operating theatre. After what seems like hours, the surgeon comes out and says: "Mrs Smith?". "Yes" I reply hesitantly. He tells me that little Johnny is in a serious condition and that the next 24 hours will be critical."

Remember: the purpose of the exercise is to feel anxious. If you are feeling anxious, upset, tearful whilst writing your imaginal exposure script you are on the right track.

At first you might find it hard to focus on your fear. This is natural, but try and bring your mind back to the task, try to avoid trying to distract yourself or "neutralising" your thoughts as you go through the exercise.

For imaginal exposure to be most effective, you should re-read (or listen to) the scenario every day for a prolonged period of time (approximately 30-60 minutes) or at least until your SUDs or anxiety go down to 2-3/10 or 20-30%.

Remember: as with normal exposure, this task can be graded. For example, you might start by writing a script about a loved one catching a cold, twisting their ankle, and then gradually writing about more negative and distressing scenarios when it feels more manageable.

Imaginal exposure is effective with people with OCD because they are often afflicted by recurrent and powerful images of possible dangers – triggered in harmless situations they tend to be highly charged and frightening – these images about future disastrous events can fuel obsessive worry and compulsive rituals.

In imaginal exposure you purposefully think uncomfortable, fear provoking thoughts and hold these in your mind until you become habituated and your distress diminishes – by holding the image in your mind and not responding to it. With this approach you will eventually be able to experience these thoughts without excessive discomfort, you will feel less anxious when you have a “bad” thought and learn to accept thoughts as what they are – JUST THOUGHTS.

Imaginal exposure is useful for (1) obsessions based on fateful catastrophes such as disasters, (2) accidents happening to loved ones, and (3) imagined or remote outcomes like being punished in hell.

We can also expose ourselves to our intrusive thoughts – written exposure or taped exposure.

Let’s try this out: to demonstrate how this works, say your name or the name of someone you have a strong feeling about, or attachment or reaction to - your child, spouse, parent, or boss, for example. Now, pay attention to your internal "feeling" reaction to this name. Then repeat the name, over and over again. Keep repeating the name a minimum of fifty times.

How do you feel now? Because of the constant repetition, your nervous system has become "bored" with the originally felt "meaning“ you had attached to this name. This is how it works: by repeating a feared thought, it loses its power and impact over you.

Keep track of your anxiety/SUDs as you go through the task. Example:

Situation	**Day/ Time**	**SUDs** Before	**SUDs** Beginning	**SUDs** Peak	**SUDs** End	**SUDs** After	**Comments**
Imagining catching a very dangerous germ which would lead me to get ill and die, leaving my children without their mother.	*Tue 6pm*	***8***	***8.5***	***9***	***7***	***5***	
Repetition 2	*Tue 8pm*	***7***	***8***	***8.5***	***6.5***	***4***	
Repetition 3	*Tue 10pm*	***6***	***7***	***7.5***	***6***	***3.5***	
Repetition 4	*Wed 10am*	***5.5***	***6.5***	***7***	***5***	***3.5***	*Every repetition was slightly easier than the previous one*

How do you feel about this task?

Do you think that there might be any difficulty or obstacle to complete this?

Remember that in the next sessions we are going to explore the thinking mechanisms of OCD, for example why sometimes thoughts can make us feel very upset even though we rationally know that they are just thoughts.

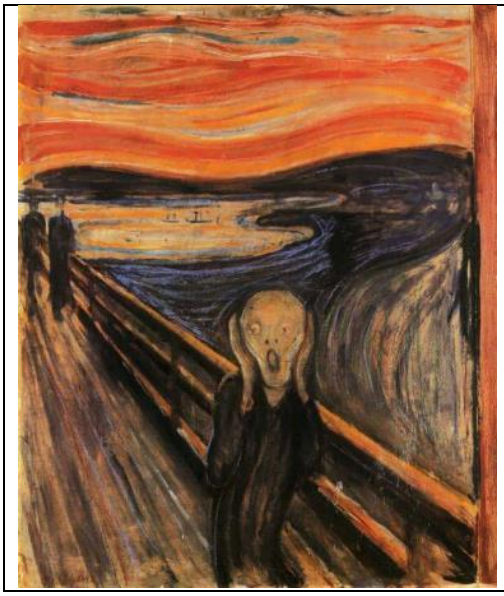
Remember: **writing it down or imagining it will not make it come true!**

The goal of the imaginal exposure script is to reduce anxiety, rather than to stop you caring. If you use the imaginal exposure script often, we can expect to notice ourselves spending less time worrying about fears. However, it does not mean that you don't care about yourself and others, rather you are just not spending as much time and energy worrying or feeling anxious about it.

When working with exposure, it might be worth keeping in mind some information and reminder to help us confront anxiety:

10 Statements for Confronting Anxiety

- Anxiety is NORMAL and TEMPORARY
- Anxious sensations feel uncomfortable - but they are NOT dangerous
- Anxiety will NOT hurt me. It's just my flight or fight/adrenalin system at work
- I have to make myself anxious to get better - If I stop now, I'll only be making it worse
- It is worth being anxious in the short term to get over this in the long term
- When I have faced my fears before - I've always eventually felt better
- Trying to control anxiety does NOT work
- I need to go with anxiety to get better
- The trigger only bothers me because I give it so much negative meaning
- I CAN handle this - I CAN let the anxiety decrease by itself

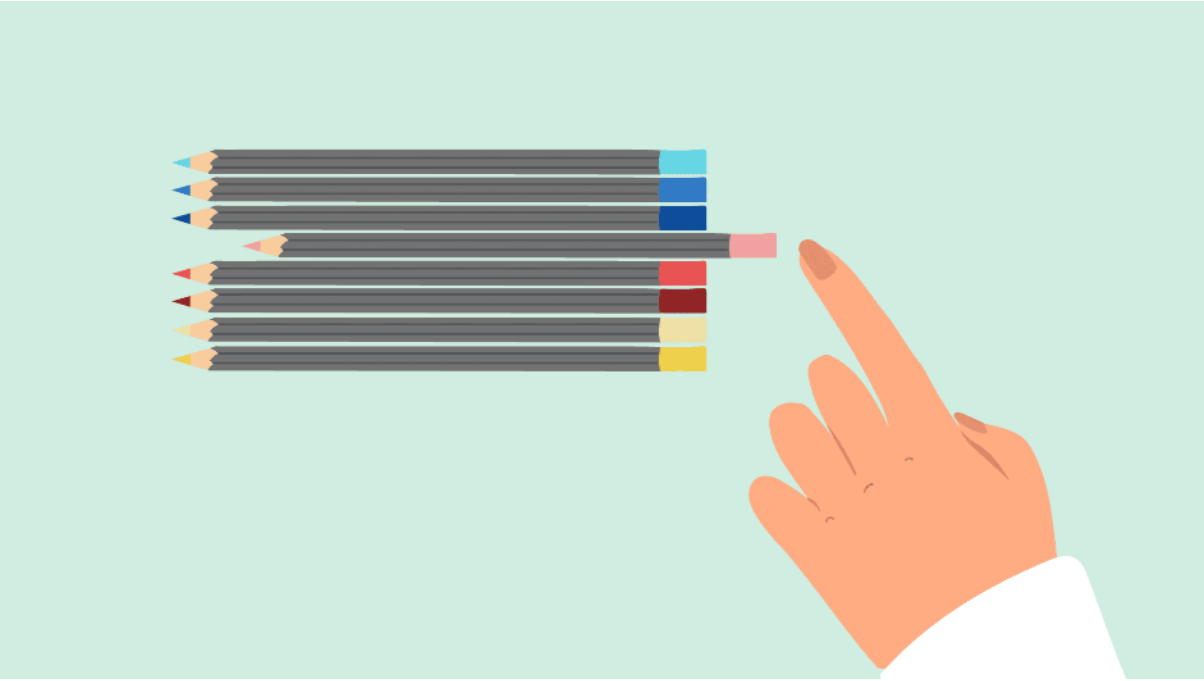


How do you feel about these statements?

Is there any of these that you find more helpful, or maybe that you would like to discuss?

Internal cues and external cues.

People with contamination and washing rituals and those with checking rituals often decide when to stop doing these rituals based on internal, emotional cues: "**When it feels right**".



People without OCD usually use external cues – e.g. *when it looks clean* - or sometimes they might use time - e.g. *after 20 seconds*.

When finishing a ritual – e.g. when working with exposure - do not go by how you feel. Instead re-focus on your attention externally, and use the environment around you. This may mean finishing your ritual while you still feel anxious, and this might be a good chance to monitor your anxiety and observe if habituation has developed.

What external cues could you use? Example:

Situation & Compulsions – Internal focus of attention	**Re-focus your attention – External/Time Cues**
Anxiety about washing my hands because of Covid-19. *Focus: I stop* ***when I feel that my hands are clean****.*	***Stop after 20 seconds****.*
Leaving the house to go on holidays for one week. Checking the door several times, **until I feel that I have checked enough**.	**Check once for maximum 5 seconds.**

Use internal/external cues to guide yourself through exposure tasks.

What can you try to focus on to stop or decrease your compulsion?

If stopping a compulsion completely is still too difficult, try to change **how many times** or **for how long** you do something. This can be included in your hierarchy of exposure and can be approached gradually as the other exposure tasks.

Example:

		SUDs - 0-10
	Touching the floor and not washing my hands at all	9
	Touching the floor and not washing my hands for an hour	7.5
	Touching the floor and not washing my hands for 45 minutes	6.5
	Touching the floor and not washing my hands for 30 minutes	5
	Touching the floor and not washing my hands for 15 minutes	3.5

Reflect and think about compulsions, rituals or repetitive behaviours that might be too difficult to stop all at once, and that might be addressed by decreasing the frequency (how many times) or duration (for how long):

Week 5 – Task 1 – Imaginal exposure script:

Try to develop imaginal exposure scenarios for your obsessive/intrusive thoughts and worries.

Include these in your hierarchy of exposure, or alternatively build a second hierarchy specifically for imaginal work.

Expose yourself to the anxiety-provoking scenarios following the criteria for exposure: **graded, focused, repeated and prolonged**.

Monitor and record how your SUDs change through the repetitions of the tasks.

Situation	**Day/ Time**	**SUDs** Before	**SUDs** Beginning	**SUDs** Peak	**SUDs** End	**SUDs** After	**Comments**

Week 5 – Task 2 – Internal/External cues:

Review your hierarchy of exposure and think how you can plan situations using external cues to arrange tasks and go through them gradually.

Consider using frequency cues (how many times?) and time cues (for how long?).

Situation & Compulsions – Internal focus of attention	**Re-focus your attention – External/Time Cues**

Week 6 – Negative Thinking (part 1)

Spotting negative thinking.

As we saw in our first sessions, one of the useful observations of CBT is that the way we think influences the way we feel. That means that when we feel anxious, it is not just the situation that has made us anxious, but rather it is the way that we are thinking about the situation that makes us feel anxious.

Read the following story and see if you can underline all the phrases that describe the way the person is thinking (beware some are quite hidden!):

Jack is consumed by fears that he has run over, or injured someone, while he is driving without him knowing it. He experiences intrusive doubts that he might have accidentally hit someone with his car while driving.

Today is a typical day. He notices a slight bump while he is driving. He checks his wing mirror. He can't see anything. He experiences an image of a body while lying in the street in a pool of blood. He worries that the bump was him hitting a cyclist.

He pulls over, and looks back at the road. It's empty. He doesn't feel okay, so he walks back. As he walks back, he counts his steps – counting in 7's makes him feel calmer. There is nothing out of the ordinary.

He returns to his car, and carries on, but later in the day he rings the local police station to see if anyone has reported an injury to a cyclist in that road today.

Unhelpful thinking habits.

When we are feeling anxious, we are more prone to patterns of unhelpful thinking. These patterns both cause anxiety and are also intensified by being anxious. Think of the "hall of mirrors" from the end-of-the-pier of the 1950's: it was a series of convex and concave mirrors that led the viewer to have a variety of exaggerated or distorted impressions of themselves. The unhelpful thinking habits (sometimes called cognitive distortions) do the same thing in the mind.

The following list highlighted some common categories of unhelpful thinking habits; however, this list is not exhaustive, but instead is intended to help give you an idea of how the patterns work.

1) Jumping to conclusions

This is where we take insubstantial evidence, and go straight to a (usually negative) conclusion.

2) Mind reading

We might like to think that we know what is going on in someone else's mind, but in fact we have no idea. Everyone's perspective on what happens is unique, and we can't guess it without asking them.

3) Crystal ball gazing, or Predictions

Looking into the future is not as reliable as we might like to think.

4) Mountains & Molehills

Problems aren't always as significant as they seem.

5) Self-critical thinking

Putting yourself down, or only seeing negative aspects of yourself or your behaviour.

6) Emotional reasoning

Assuming that feelings reflect facts. "*Things feel bad, so they are bad*", "*I feel anxious, so something bad will happen*".

7) Catastrophising

Imagining and believing that the worst possible thing is definitely going to happen. What is most likely to happen?

8) Black and White thinking

Believing that something or someone can be only good or bad, right or wrong, rather than anything in-between or 'shades of grey'.

9) Magical thinking

This is the belief that one's thoughts have the ability to affect what happens in the real world.

Identifying Unhelpful thinking habits.

Look through the list of cognitive distortions, and then try to identify which of the habits you can recognise in each of these thoughts (there may be more than one). Insert the letters in the table below. Then, try to think about other examples for each of the category and write them down in the table.

a) If I touch the floor, I'm going to get vomiting bug
b) If I make a spelling mistake in the email, I will be fired
c) If I don't go back and check the lock five times, someone will break in
d) I am a horrible person just for having those thoughts
e) If I touch a public toilet, I might get HIV
f) If I stop my rituals I will not be able to relax and enjoy other things
g) I need to check the tap many times, until things feel right, otherwise the sink will flood
h) Good people never have violent or inappropriate thoughts
i) If my house is not perfectly clean, my guests are going to think that I am a failure
j) I feel that something bad might happen, so I need to check more until it feels right
k) If I have thoughts about being violent, that means that I am a bad person
l) If I stop checking, my anxiety will not go away

Jumping to conclusions	
Mind reading	
Crystal ball gazing, or predictions	
Catastrophising, or making mountains out of molehills	
Self-critical thinking	
Emotional reasoning	
Catastrophising	
Black and White thinking	
Magical thinking	

Intrusive Thoughts.

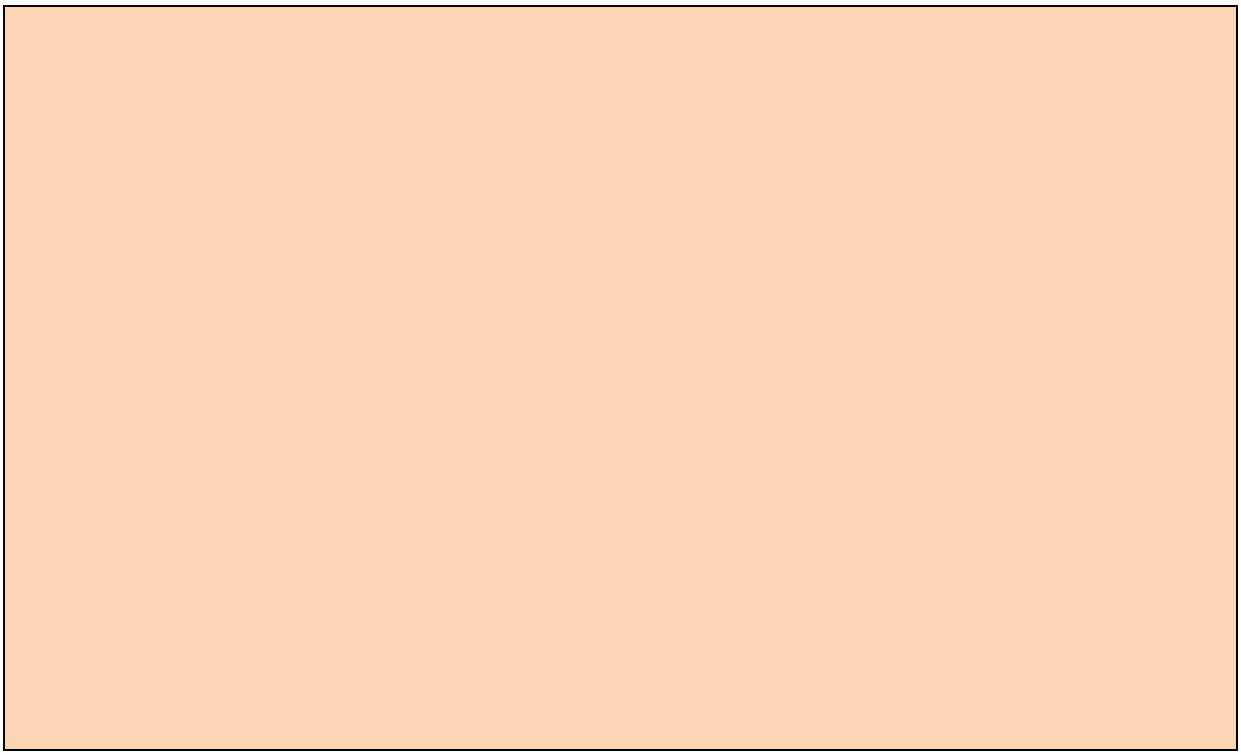
A particular kind of mental process often experienced in OCD is defined as "intrusive thought". An intrusive thought is an unwelcome involuntary thought, image, or unpleasant idea that may become an obsession, is upsetting or distressing, and can feel difficult to manage or eliminate.

Let's have a look at common types of intrusive thoughts experienced by many people – **with or without OCD symptoms**:

Some common intrusive thoughts reported by members of the public:

Harming
• Thought of jumping in front of a car. • Thought of throwing a baby down the stairs. • Idea of taking a meat cleaver and threatening someone in the family. • Image of a loved one coming to harm. • Image of hitting a pedestrian with my car.
Contamination or disease
• Fear of harm to family through exposure to asbestos. • Thoughts of catching a disease through touching a toilet seat. • Idea that dirt is always on my hands. • Idea of contracting a disease through contact with a person. • Thought of contracting a serious disease from a public pool.
Inappropriate or unacceptable behaviour
• Impulse to say something nasty and damning to someone. • Image of myself singing inappropriately at a friend's funeral. • Thought of having sex with someone under age. • Thoughts of acts of violence in sex. • Idea of sex with a family member.
Doubts about safety and memory
• Thought that I haven't locked the house up properly. • Image that my house has burnt down and I've lost everything I own. • Idea that objects are not arranged perfectly. • Idea that I haven't put my handbrake on properly, so my car will roll.

Can you think of any other kind of intrusive thoughts that people can experience, and that it is not listed above?



Mental Contamination

Contact contamination – the one with which we are usually more familiar – is defined as a feeling of dirtiness or discomfort in response to physical contact with potentially harmful substances, disease or dirt, which might contaminate the body – most frequently the hands. Relief can be usually felt in response to cleaning:

- You touch something dirty
- Your hands become dirty
- You wash your hands
- You feel relief

However, sometimes feelings of discomfort and dirtiness can also be triggered without any physical contact with something that is considered dirty or contaminated.

Mental Contamination leads to an internal sense of dirtiness, rather than being localized to a particular body part, and therefore usually it cannot be cleansed away by hand washing. Feelings of mental contamination can be sometimes triggered by association with a person who has betrayed or harmed us in some way, or even by thoughts, images or memories. Without a visible cause or trigger, it is often challenging to identify the source of discomfort.

Examples:

Jennifer started feeling internally dirty after she found out that her husband was cheating on her and her marriage broke down. She would feel dirty and wash her hands after touching any of his possessions or speaking to him.

Steve experienced mental contamination that was triggered by intrusive images of coming in contact with contaminated people or objects.

The source of mental contamination is not an external contaminant such as an object, dirt or blood, but rather human interactions. The types of emotional violations which can cause mental contamination include degradation, humiliation, violence, painful criticism, betrayal.

Imagine that you are taking part in an experiment, in which you are asked to try on a jumper which was brought from a charity shop and then report your feelings.

If you knew the jumper was physically clean, you would probably feel fine, no discomfort, you might even like wearing it.

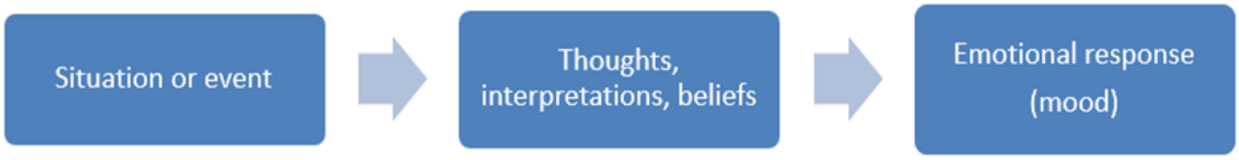
Now, imagine being told that the jumper belonged to a murderer, and suddenly for no explainable reason you are not okay with wearing it anymore. You have that disturbing, spine-tingling, shivery feeling as if the jumper was made of bugs.

Despite knowing the jumper is physically clean, there is a cloud of dirtiness hanging over it, and you feel mentally contaminated - or even worry that somehow you will adopt the negative traits of the murderer through their clothing!

Most people experience the same type of bad or unwanted thoughts that people with more troubling intrusive thoughts have, but most people can dismiss these thoughts easily as they do not consider them important or worrying.

For most people, intrusive thoughts are a "fleeting annoyance" in the worst case.

Remember the model we introduced in the first session:



If the situation or event is an intrusive thought or image, it will be our interpretation and set of beliefs which will determine how we feel about having that particular intrusive thought or image.

This means that the same intrusive thought or image can have completely different effects on different people.

Also intrusive thoughts associated with mental contamination are normal, but it is the interpretation of the thoughts that is important in determining whether or not the person will then engage in compulsive behaviours.

For people not struggling with OCD, these are just uncomfortable feelings which are easily dismissed and forgotten.

Intrusive Thoughts in Nonclinical Subjects

The table below shows the results of research findings from a survey of 293 students (198 female, 95 male), none of who had a diagnosed mental health problem.

The column on the left shows the type of intrusive thought and the two columns on the right show the percentage of men or women who said they had experienced that particular thought.

This research is from C. Purdon and D.A. Clark (1992): *Obsessive Intrusive Thoughts in Nonclinical Subjects. Part 1 Content and relation with depressive, anxious and obsessional symptoms. Behaviour Research and Therapy 31, 713-720*

Item	Female%	Male%
1. Driving into a window	**13**	**16**
2. Running car off the road	**64**	**56**
3. Hitting animals or people with car	**46**	**54**
4. Swerving into traffic	**55**	**52**
5. Smashing into objects	**27**	**40**
6. Slitting wrist/throat	**20**	**22**
7. Cutting off finger	**19**	**16**
8. Jumping off a high place	**39**	**46**
9. Fatally pushing a stranger	**17**	**34**
10. Fatally pushing friend	**9**	**22**
11. Jumping in front of train/car	**25**	**29**
12. Pushing stranger in front of train/car	**8**	**20**
13. Pushing family in front of train/car	**5**	**14**
14. Hurting strangers	**18**	**48**
15. Insulting strangers	**50**	**59**
16. Bumping into people	**37**	**43**
17. Insulting authority figure	**34**	**48**
18. Insulting family	**59**	**55**
19. Hurting family	**42**	**50**
20. Choking family member	**10**	**22**
21. Stabbing family member	**6**	**11**
22. Accidentally leaving heat/stove on	**79**	**66**
23. Home unlocked, intruder there	**77**	**69**
24. Taps left on, home flooded	**28**	**24**
25. Swearing in public	**30**	**34**
26. Breaking wind in public	**31**	**49**
27. Throwing something	**28**	**26**
28. Causing a public scene	**47**	**43**
29. Scratching car paint	**26**	**43**
30. Breaking window	**26**	**43**
31. Wrecking something	**32**	**33**
32. Shoplifting	**27**	**33**
33. Grabbing money	**21**	**39**
34. Holding up bank	**6**	**32**
35. Sex with unacceptable person	**48**	**63**
36. Sex with authority figure	**38**	**63**
37. Fly/blouse undone	**27**	**40**
38. Kissing authority figure	**37**	**44**
39. Exposing myself	**9**	**21**
40. Acts against sexual preference	**19**	**20**
41. Authority figures naked	**42**	**54**
42. Strangers naked	**51**	**80**
43. Sex in public	**49**	**78**
44. Disgusting sex act	**43**	**52**
45. Catching sexually transmitted disease	**60**	**43**
46. Contamination from doors	**35**	**24**
47. Contamination from phones	**28**	**18**
48. Getting fatal disease from strangers	**22**	**19**
49. Giving fatal disease to strangers	**25**	**17**
50. Giving everything away	**52**	**43**
51. Removing all dust from the floor	**35**	**24**
52. Removing dust from unseen places	**41**	**29**

The problem with intrusive thoughts is that the more efforts we make not to think about them, the more we think about them and the more we feel upset about this.

Trying NOT to think about something does NOT work.

The task which you are about to undertake, variously known as the “blue polar bear”, tells us that trying NOT to think about something does not work.

Look at this picture and then try your best not to think about it:

When we try not to think about something, this often leads either to:

- **Enhancement** - An increased focus at the time, or
- **Rebound** - Where it pops back into your head at a later time

Trying to block or avoid upsetting thoughts or worries can actually lead to more such thoughts in your mind. You may want to try this out as an experiment this week.

A key motto to remember once again is:

"A thought is just a thought"

Sometimes **distraction** can work. The principle of distraction is to move the focus of attention towards **something that you find intrinsically interesting or pleasurable**. That might be planning your next holiday, contemplating your retirement plan or recalling a first date.

Week 6 – Task – Thought Diary:

This week we would like you to continue using diaries, but with a special focus on trying to spot **unhelpful thinking habits**. Refer to the list of unhelpful thinking habits above and fill the table below:

Situation:	**Thought:**	**Unhelpful thinking habit:**	**Emotions:**	**What happened in your body:**	**Behaviour:**

Week 7 – Negative Thinking (part 2)

Experiments in Magical Thinking.

Last week we discussed a series of common unhelpful thinking habits (otherwise called cognitive distortions). Many people who struggle with OCD often experience a particular cognitive distortion: **magical thinking**. There are three different main types of magical thinking in OCD.

1) **Though-Action Fusion (TAF) -** Thought-Action Fusion (TAF) is the belief that simply thinking about an action is equivalent to actually carrying out that action.

2) **Thought-Event Fusion (TEF) -** Thought-Event Fusion (TEF) is the belief that experiencing a thought has caused or might/will cause an event.

3) **Thought-Object Fusion (TOF)** - Thought-Object Fusion (TOF) is the belief that thoughts, memories and feelings can contaminate an object.

Though-Event Fusion (TEF) is the idea being that "*If I think it, then it is real [or it's going to happen]"*. Where the person believes that having a "bad" thought can produce a bad consequence (e.g. *believing that thoughts about my partner having a car crash can make that more likely to happen and, consequently, that some action must be taken to prevent this from happening*).

How much evidence is there to support this?

In reality this has no more evidence than the notion from the mists of fairy stories and medieval history that if a witch or wizard said a special set of words (a "spell") then this would change the course of events. We now know that this has no evidence in reality.

Let's start off with something nice. If you think that your thoughts can alter the outcome of events, try this test. Please try very hard with this one.

Imagine your therapist(s) winning the lottery.

Imagine them checking the numbers.

Telling their partner.

The amazement on their faces.

Phoning the lottery.

Confirming it all.

A picture for the local paper.

A trip to the local Porsche showroom.

Your therapists will this week go out and buy a lottery ticket each, and next week see what happens.

Now, if they return empty handed the next task is a more uncomfortable one:

This time imagine your therapist being involved in a bad car accident.

The screech of brakes.

The ambulance sirens.

The assessment in A&E.

Is this more difficult? But if they did not win the lottery, what makes this task harder?

You can also try this with superstitious numbers. One experiment might be to write the number 666 on a large piece of card, and prop it up in front of your mirror. Remember: you need to make specific predictions first, so you know what you are testing out.

Though-Action Fusion (TAF) is when someone believes that having a thought about something (e.g. having sex with a family member) is as bad as doing that thing.

If a person believes this sincerely, then this makes such thoughts very frightening.

Discuss the following:

- Have you ever said something about, or thought about, robbing a bank?
- Have you ever desired to do something violent to someone who really frustrated you?
- Have you ever stood on a train platform and thought, in an idle kind of way, with no intention of doing it, that you could jump under the oncoming train?

➢ Does thinking about these things mean that you really wanted to do them?
➢ Did you intend to do them?
➢ How busy would the courts be if everyone who ever had such a thought or fantasy about an illegal act was prosecuted?

Think about a scale of wrong doing from "0 = neutral" to "10 = the most evil person I can think of". Try to think of someone here - e.g. a famous serial killer.

- Where do you put a serial killer who killed many people?
- Where do you put someone who killed their spouse after years of abuse?
- Where do you put someone who planned to kill someone, but did not do it?
- Where would you put someone who had a desire to kill someone, but who would never consider acting on this desire?
- Where do you put someone who had a thought about killing someone, but was appalled that they had had that thought?

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

How do I know I'm not a paedophile?

People with intrusive thoughts and obsessions have had thoughts come into their mind, and they have been deeply shocked by those thoughts, and they then get caught up in ruminating on those thoughts, and with time they start to take up safety seeking behaviours, and rituals to help them cope with these thoughts.

Bob thought he might be a paedophile.
The first time that this thought crossed his mind he was deeply shocked.

As he continued to worry about this thought he changed his routes to avoid schools and playgrounds, and became more avoidant when his young nieces and nephews came to stay. Eventually he refused to have anything to do with them, which, as his brother and sister in law did not understand OCD, caused a lot of problems in the family.

Bob was reluctant to come to therapy, and wondered what the therapist would make of him, but with the encouragement of his GP he decided to come along.
He said to his therapist: "How do you know I'm not really a paedophile and a danger to the public?". His therapist suggested using a Theory A and Theory B technique, which means developing two opposite theories and looking for evidence. It looked like this:

Theory A: I am a dangerous paedophile and need to be kept away from children.
Evidence:

- *I think a lot about whether or not I am a paedophile*
- *I have intrusive thoughts about being a paedophile*

Theory B: Although I have intrusive thoughts and I spend a lot of time worrying about whether I could be a paedophile, I would never harm a child and I am no more or less a risk to children than anyone else in the general population.
Evidence:

- *I am not sexually aroused by children*
- *Indeed, I am repulsed by such thoughts*
- *I am disgusted by what I have read about paedophiles*
- *I have never acted in this way*
- *I have sought therapy for help with my problem*

With the help of the therapist, Bob realised that this thought [of abusing children] was totally out of tune with his personal values, so that he was totally petrified of the thought of this possibility.

That is to say his thought was ***ego-dystonic.***

Ego-dystonic refers to thoughts, impulses, and behaviours that are felt to be repugnant, distressing, unacceptable or inconsistent with one's self-concept and values. It is often ego-dystonic thoughts that we find most shocking.

Our subconscious is like a geyser, constantly chucking up random thoughts from the murky depths. These thoughts, that appear randomly, will often focus on things we find emotionally evocative. It will often mix things up, so taking something shocking, like abusing children, and then creating a thought: “I could be a paedophile”.

What happens is that, when a person starts to believe these thoughts, they become even more emotionally evocative, as they will start to cause anxiety, distress, disgust. These strong emotions will therefore make it even more likely for the person to experience these automatic intrusive thoughts again. Remember the “Blue Polar Bear”?

Week 7 – Task 1: Behavioural Experiments

Start experimenting situations to test your negative predictions about situations.

Remember to specify: are you testing Though-Action Fusion (TAF), Thought-Event Fusion (TEF) or Thought-Object Fusion (TOF)?

Write both your usual negative prediction and what would be a different, positive one – even if you don't believe in it!

Remember: behavioural experiments are not the same as exposure.
Exposure is aimed at developing habituation to your anxiety in a certain situation.
Behavioural experiments are aimed at testing a certain belief or prediction.

Situation/ Experiment **Are you testing TAF, TEF or TOF?**	**Negative prediction – Rate strength 1-100%** **What is the consequence that I fear?**	**Alternative positive prediction – Rate strength 1-100%**	**Outcome – What happened?** **Did my negative prediction come true?**	**What did I learn?**

Week 7 – Task 2: Theory A Vs Theory B

Read again Bob's story, then think about a common and distressing worry related to your OCD.

What is your negative theory (Theory A)? And what could be an alternative, more positive one (Theory B)?

Write the theories down, then try to think and write down evidence for each theory.

Theory A	Theory B
Evidence:	**Evidence:**

Week 8 – An OCD Formulation

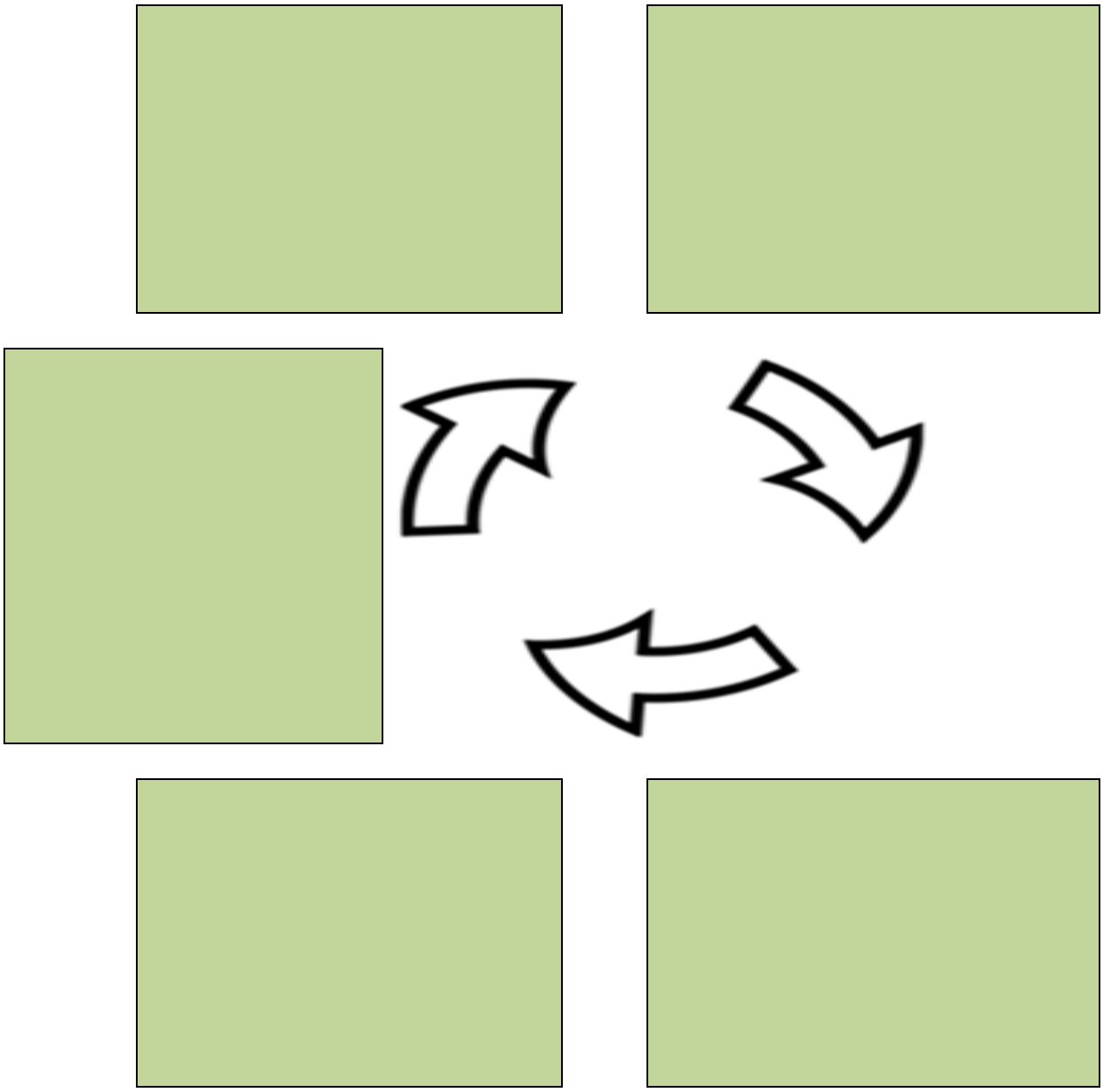
Now that we have looked at some important aspects of OCD both from a behavioural and cognitive (thinking) points of view, it can be very helpful to summarize and organize the main information in what we call a **Formulation**.

This understanding can be therapeutic in itself as formulating normalises what we are experiencing; at the same time, mapping out a problem helps with highlighting what needs to be treated.

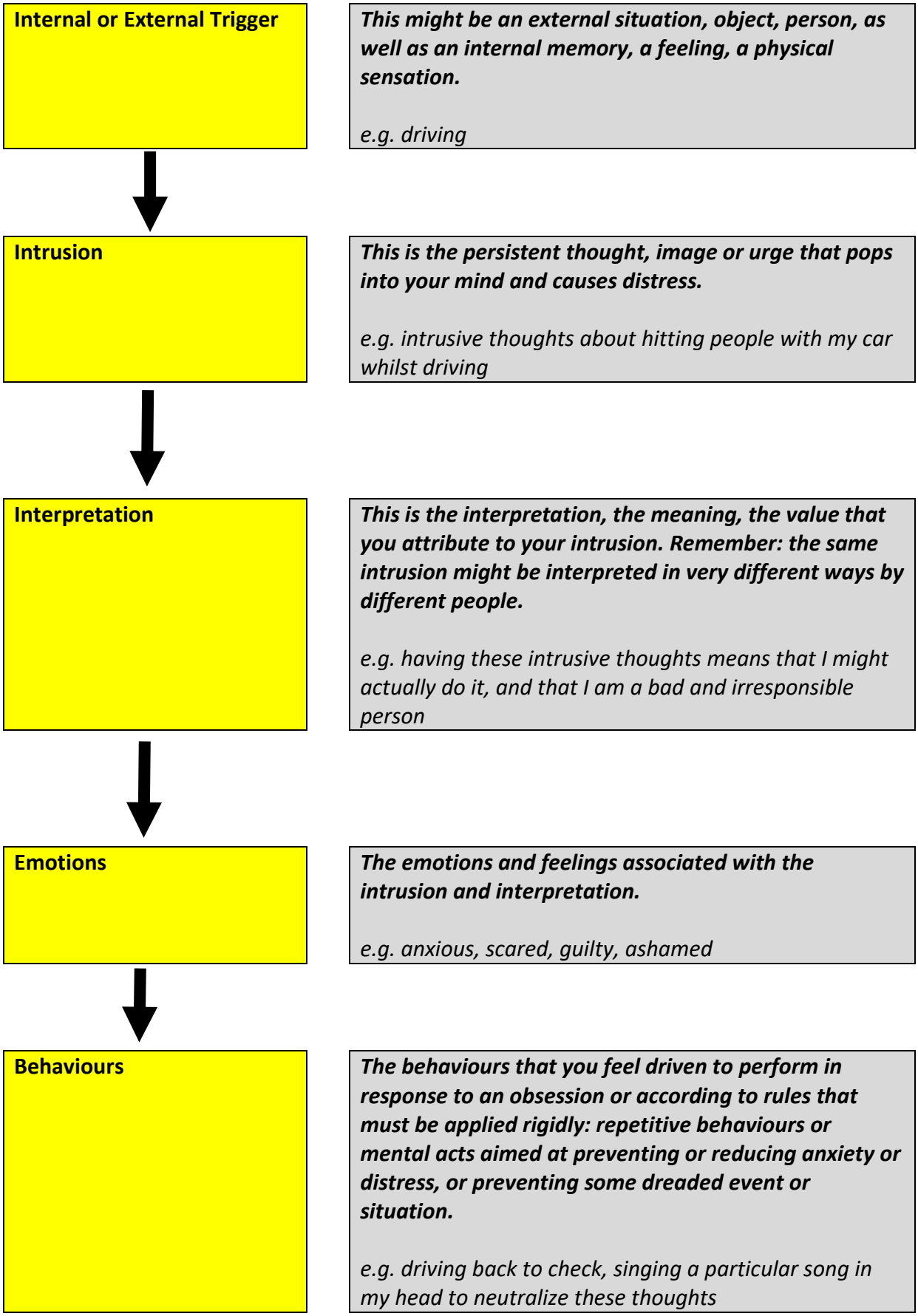
A CBT formulation simplifies and explains difficulties that might seem complicated and hard to grasp, and it can be also tailored to an individual and easy to adapt and personalise.

A formulation in Cognitive-Behavioural Therapy refers to vicious cycles. When someone suffers from low mood or anxiety, we have seen that they might get stuck in a pattern of feelings, thoughts and behaviours, which become all interconnected. Mapping out how these elements are connected to one another becomes important to understand how the difficulties are triggered and maintained **in the here and now**, and how to tackle them and break the vicious cycles.

At this point of our sessions, what would you say are the 5 main elements that form a vicious cycle of OCD? Try to remember and guess:

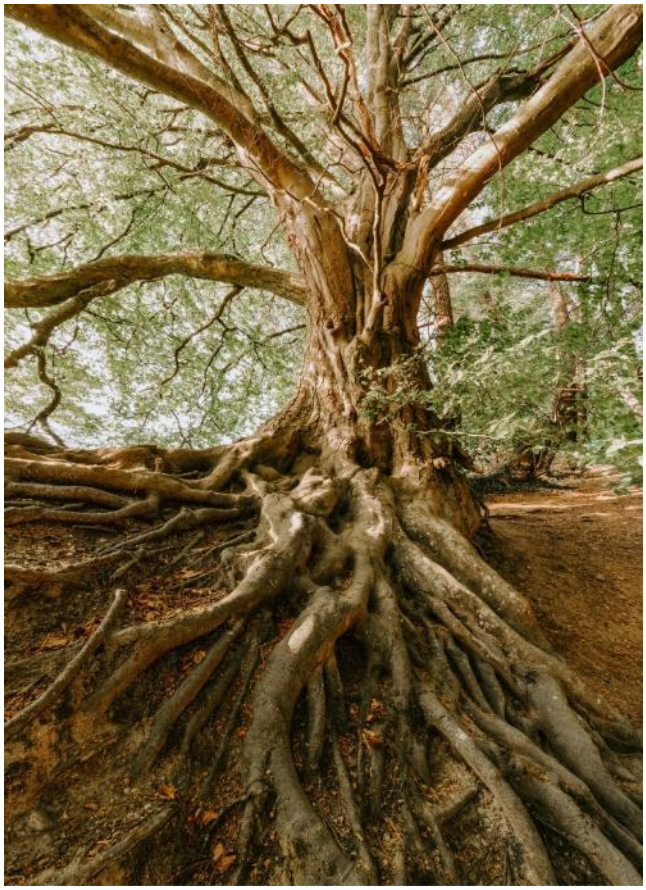


Now, let's have a look together at how we can describe a vicious cycle of OCD in a CBT formulation:



Formulations in CBT sometimes also include information about the past. This is what we call the **longitudinal** part of the formulation, and it can be important to understand and make sense of how some problems developed.

Imagine a tree:



Negative Automatic Thoughts

(Core) Beliefs

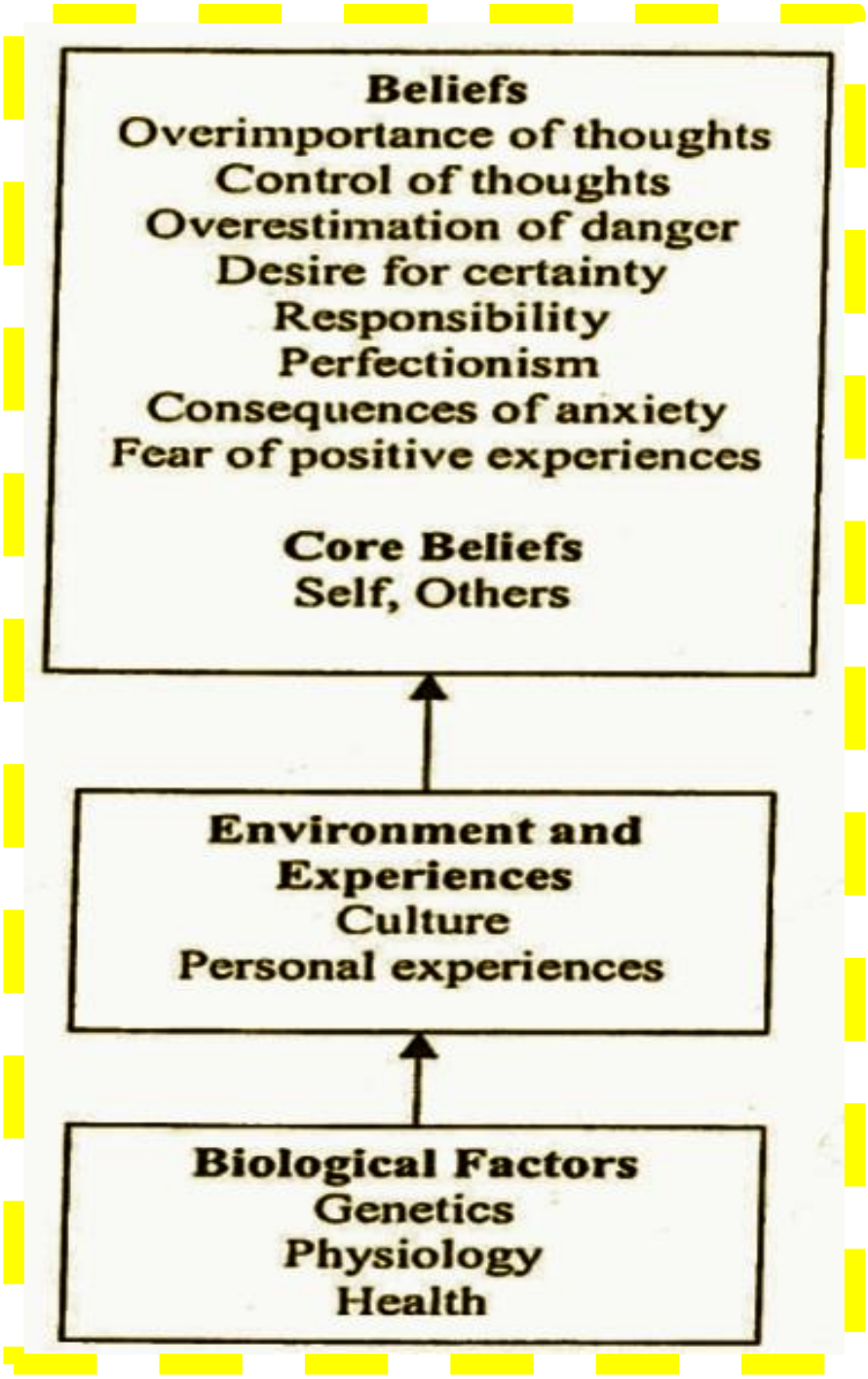
Biological Factors,
Environment, Life Experience

A tree can be a helpful analogy.

Negative automatic thoughts (our intrusive thoughts, interpretations, negative thoughts, images) are like the leaves, they are the easiest to access, and there may be many of them.

Core beliefs are deeply held, and may be more difficult to access. They feed negative thoughts, much like roots sustain a tree.
Core beliefs present as fundamental beliefs about the self, others/the world and the future. They can be unconscious or not fully conscious, and they are usually felt as absolute truths which apply to all situations.
Core beliefs are developed as a result of biological factors, environment and life events/experiences.
Examples: "*I am a failure*", "*Others are cruel*", "*The world is unfair*", "*The future is bleak*".

Let's have a look at how this can be described in a formulation:



Can you think of any imaginal examples of how someone's past experience might influence their core beliefs and the way they think in the here and now?

Think also about the **unhelpful thinking styles** that we have seen in our previous sessions.

Past Experience	**Core Beliefs (about self, others/world, future)**	**Negative Automatic Thoughts**
e.g. bullying at secondary school	*I am unlovable* *People are mean* *The world is dangerous*	*There is no point in trying to make friends* *If I go to that party nobody will like me*
e.g. parents with old-fashioned mentality and with very strong and strict values and rules	*I am a bad person*	*Having unacceptable intrusive thoughts and images means that I am bad*

Although we have highlighted how anxiety is a primary element of OCD, people who experience OCD can often experience low mood or depression as a consequence of their distress or of the impact of OCD on their lives. Therefore, **mood** is an important element to consider in a formulation for OCD.

Some people think depression is trivial and not a genuine health condition. They're wrong – it is a real illness with real symptoms. Depression is not a sign of weakness or something you can "snap out of" by "pulling yourself together".

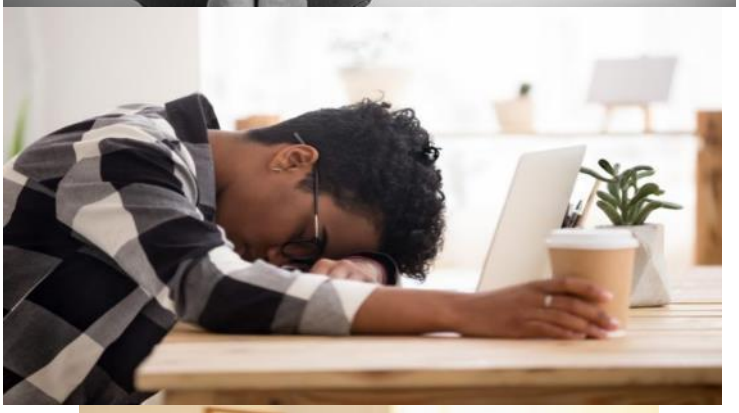
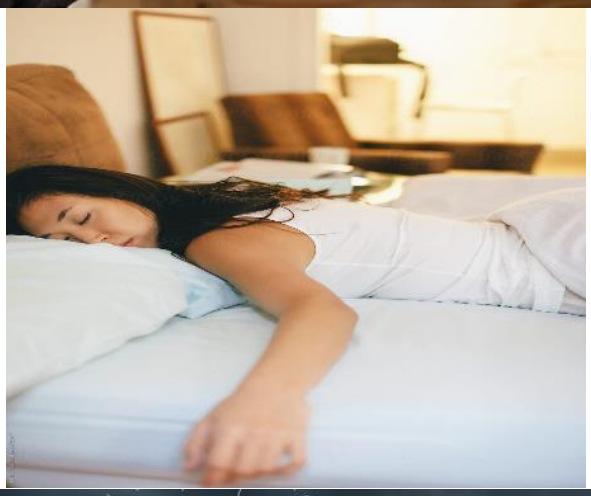
Depression affects people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of unhappiness and hopelessness, to losing interest in the things you used to enjoy and feeling very tearful.

There can be physical symptoms too, such as feeling constantly tired, sleeping badly, having no appetite or sex drive, and various aches and pains.

The symptoms of depression range from mild to severe. At its mildest, you may simply feel persistently low in spirit, while severe depression can make you feel suicidal, that life is no longer worth living.

Most people experience feelings of stress, anxiety or low mood during difficult times. Low mood may improve after a short period of time, rather than being a sign of depression.

Depression can form a vicious cycle too, which usually includes:

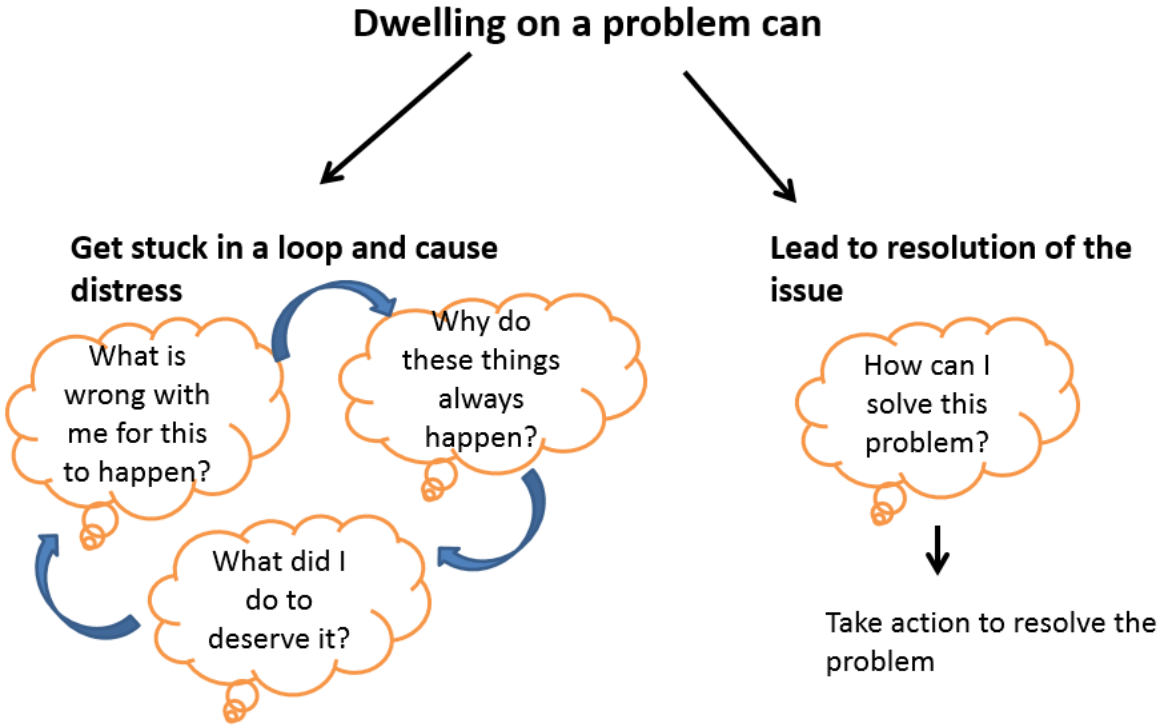
Low mood	
Lack of physical and mental energy	
Reduction of activity and socializing	
Thinking more negatively	

It is very important to consider depression in the context of OCD, also because experiencing periods of low mood can contribute to the worsening of the OCD symptoms – and vice versa.

Rumination

A key symptom of Depression is often rumination. Rumination can be a symptom of both anxiety and depression. It means repetitively going over negative thoughts or problems without completion. When people are depressed, the themes of rumination are typically about being inadequate or worthless. The repetition and the feelings of inadequacy raise anxiety, and anxiety interferes with solving the problem. The incapacity of solving the problem makes depression worse.

Rumination means getting caught up in repetitive loops of thinking about negative things (e.g. that have happened in the past), going over and over the same thought again and again. It can be about us or other people and events.



In OCD rumination refers to prolonged thinking about a question or theme that is undirected and unproductive. Differently from obsessional thoughts, rumination is often indulged rather than resisted. Rumination in OCD often dwells on religious, philosophical or metaphysical topics, such as morality. Examples might be wondering if everyone is basically good, or what happens after death, etc.

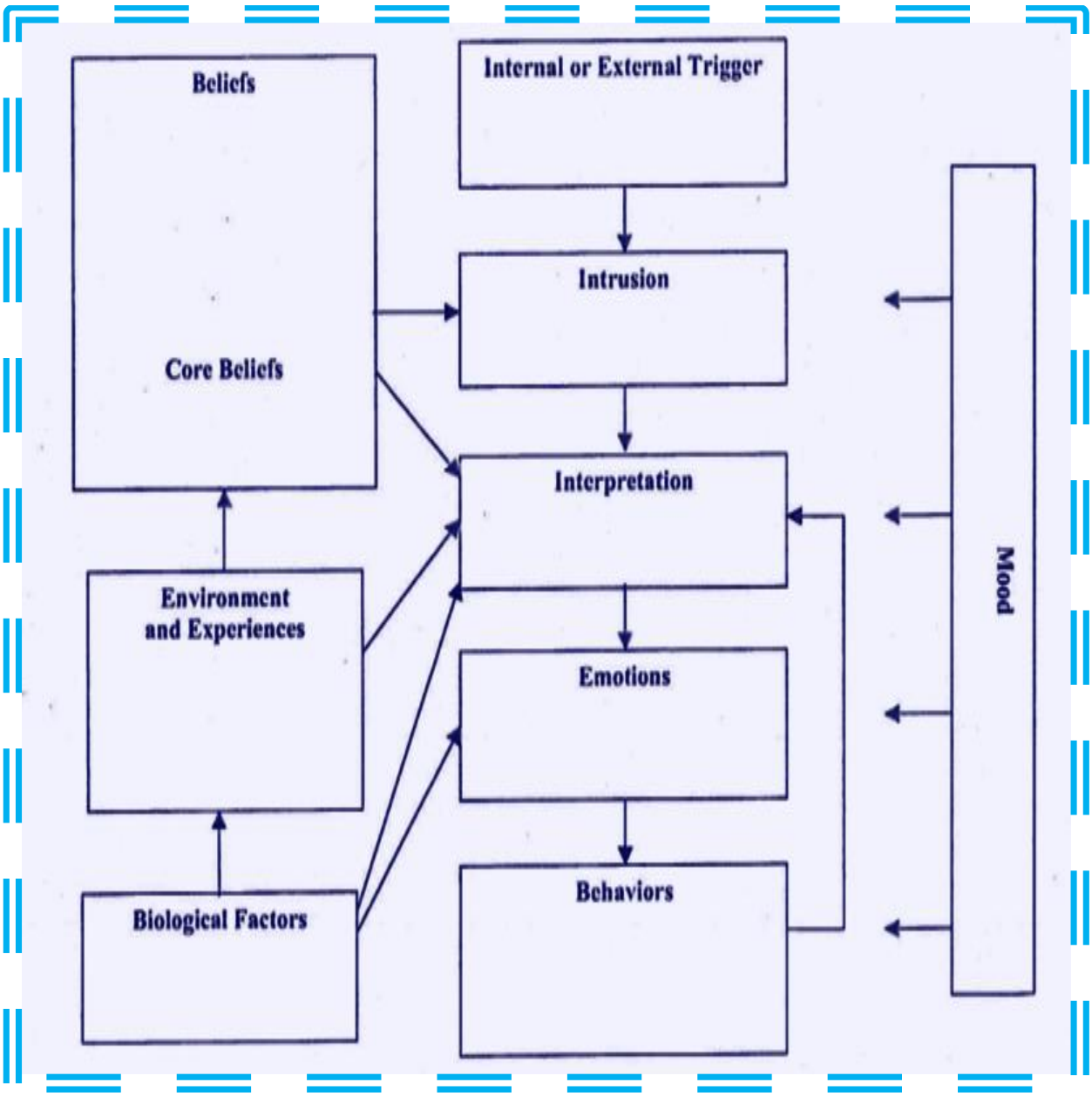
Rumination never leads to a solution or satisfactory conclusion and the person might end up being constantly preoccupied and worried.

Rumination Cues Action

You can try to use rumination as a cue to get active. Use the form below to recognise and label rumination. Say to yourself: “This is ruminating”:

Situation	Rumination	Consequence	Alternative Action	Consequence
Driving to work on Monday	*I’m stuck in a bad relationship* *I’ll never be happy or fulfilled in my life*	*Felt more depressed* *Almost drove over a zebra crossing without looking*	*Sing along to the radio* *Attend to what I can see whilst driving* *Plan work activities*	*Felt more energized and concentrated*

To recap: we have seen how past experiences and core beliefs can affect how people experience OCD symptoms in the present moment, and how our mood can also influence - and be influenced by - these symptoms.
Considering all the factors, this is how a complete and comprehensive OCD formulation in CBT would look like:



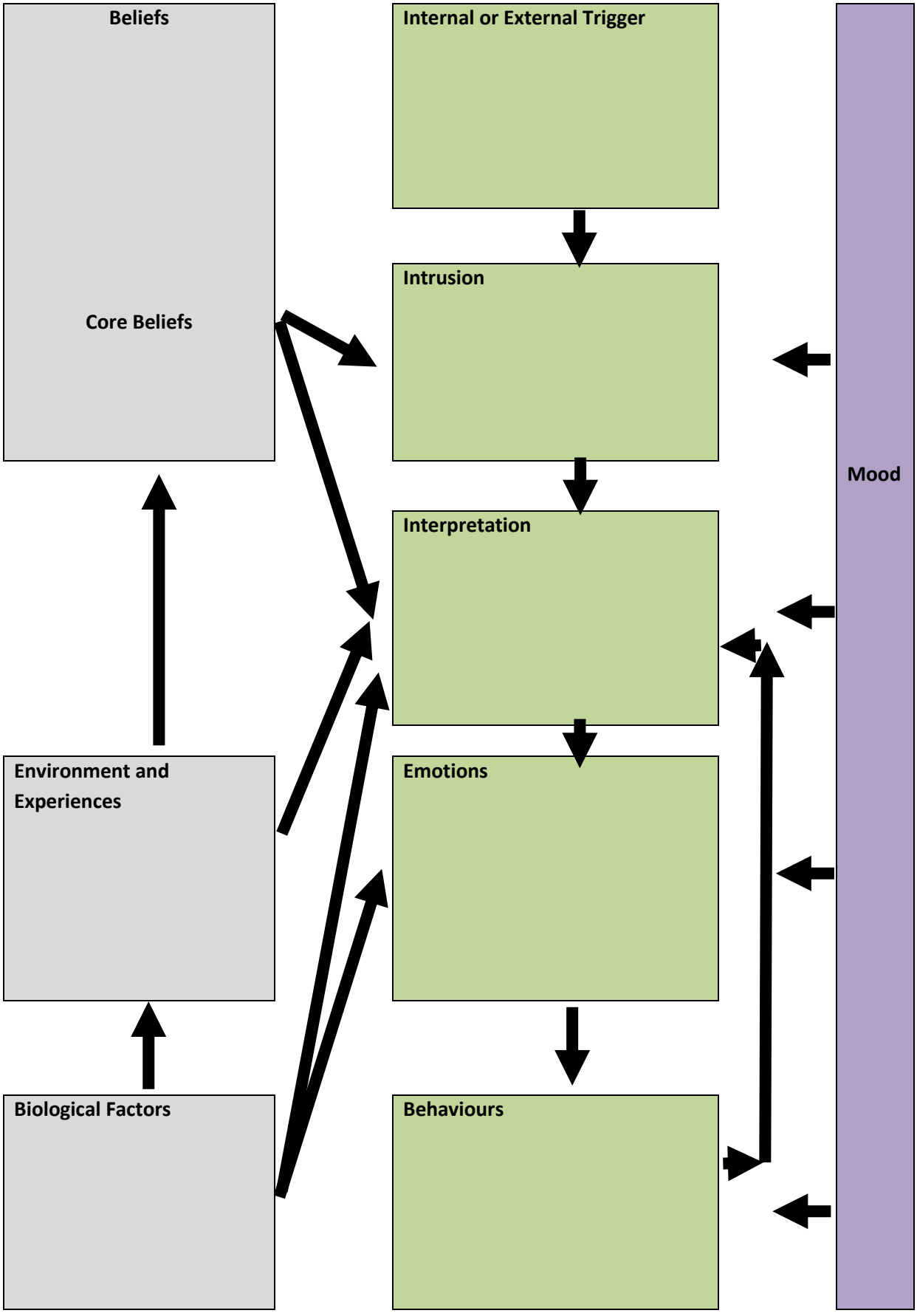
Week 8 – Task: Formulation

Looking at the OCD complete formulation above, try to fill the diagram below using your own personal information. Try to see how they are all linked, and how becoming aware of these connections might make it easier for you to make sense of your difficulties, feel more in control and break the vicious cycles.

Remember: a formulation is NOT you; a formulation is a diagram which describes a hypothesis, an idea of the problem(s) that we want to identify and tackle. It is like an X-ray of a broken leg, a map of an issue that helps us breaking it down and working on it.

Remember: there is no right or wrong. The formulation needs to make sense for you and make you feel more in control of your difficulties.

If you feel that you cannot think of any information to insert in a particular box, this is ok and it does not mean that you are doing it wrong.


Beliefs
Core Beliefs
Internal or External Trigger
Intrusion
Interpretation
Emotions
Behaviours
Mood
Environment and Experiences
Biological Factors

Week 9 – Challenging negative thoughts

Looking for Evidence

In Cognitive-Behavioural Therapy, when we challenge negative thoughts, sometimes we say that we “bring these thoughts to court”.

Imagine two layers who have to look for evidence to confirm or disprove the initial idea, belief or hypothesis.

One good way of dealing with difficult OCD thoughts is to look at it from the point of two competing theories, that we might call **Theory A and Theory B**.

We want to treat Theory A as "the problem", the OCD problem we want to address; and Theory B as a hypothesis that the issue might not be the problem itself, but the worry and anxiety about that particular situation.

Let's look at an example:

Theory A	Theory B
The problem is that germs are everywhere, and those germs are potentially dangerous and likely to harm me, so I have to wash all fruit in disinfectant, or peel them, to make sure that they are safe.	*The problem is that I am worried about germs being everywhere and concerned that they are dangerous and harmful to me.*

We might then look for evidence for each side of this.

Theory A - Evidence	Theory B - Evidence
• *It feels safer;* • *I've read about dangerous germs.*	• *Most of my friends only wash fruit in water;* • *If unwashed fruit was so dangerous surely there would be public health campaigns about it;* • *Although there are germs everywhere, my body has enough natural defences, and it's okay to just wash fruit in water;* • *Even if I eat unwashed fruit sometimes, nothing bad has happened.*

Once we have looked for evidence for Theory A and B, we need to reflect and figure out what we should do if Theory A was true, and what we should do if Theory B was true:

What do I need to do if Theory A is true?	What do I need to do if Theory B is true?
• *Wash all fruit in disinfectant;* • *or peel them, to make sure that they are safe;* • *Spend 15-20 minutes washing all fruit.*	• *Wash fruit only in water;* • *Spend maximum five minutes on this task.*

Can you now try to use your imagination to construct a different example of Theory A and Theory B?

Theory A	Theory B
Theory A - Evidence	**Theory B - Evidence**
What do I need to do if Theory A is true?	**What do I need to do if Theory B is true?**

Once you complete the process of:

- Defining Theory A and Theory B
- Looking for evidence for both
- Figuring out what you need to do

A very effective way to bring this process forward is to work with behavioural experiments, to test either Theory A Vs Theory B or Theory B alone. Remember how to set up a behavioural experiment?

Situation/ Experiment	**Negative prediction – Rate strength 1-100%** **What is the consequence that I fear?**	**Alternative positive prediction – Rate strength 1-100%**	**Outcome – What happened?** **Did my negative prediction come true?**	**What did I learn?**
e.g. Wash fruit only in water; spend maximum five minutes on the task.	*Within a month, I and/or some members of my family will get sick – 70%*	*Everyone will be fine – 35%*	*…*	*…*

We might need to test out the empirical basis for these fears, as well as what will happen if we break our rituals. Examples of behavioural experiments:

Jodie has a form of OCD where she compulsively checks the digits on her bank transfers so that the whole process can take 30 minute or more – sometimes she just gives up.
Working with her therapist Jodie was asked to deliberately write an incorrect bank account number on the transfer to determine whether the money is sent to the incorrect person, and if so, whether it is possible to get the money back.

Or: transfer a small amount where the name and number do not match.

Steve compulsively checked taps. His experiment was to put the plug in the sink, then to leave the tap deliberately dripping, and to see how long it took for the sink to fill up.

It is important that all behavioural experiments must include the hypothesis or prediction that is being tested.

Behavioural experiments are important because they allow us to test the evidence for and against the alternative appraisals; but also because they allow us to step out of our comfort zone and break the vicious cycles.

Surveys

Surveys are a particular form of behavioural experiments. Conducting a survey helps us to gather more information.

As with behavioural experiments, it is important to write down your predictions before getting the answers from the people to whom you are going to ask your questions. with surveys, rather than having a negative and positive prediction, we want to have a single prediction and then find out if it was accurate, and what we can learn from the outcome of the survey.

Surveys can be useful to normalize and validate your difficulties, but also to help guide and add to your goals.

Example of survey:

Survey **What will I ask? What questions? How? To whom?**	**Prediction – Rate strength 1-100%**	**Outcome** **Was my prediction accurate?**	**What did I learn?**
I will ask my friends how long they spend checking an important email before sending it. I will do this in our group chat.	*I think that the average answer will be around 10-15 minutes*	*There were very different answers, but overall they spend less than 5 minutes checking the email*	*Although I sometimes believe that it is absolutely necessary to check an important email for at least 15 minutes before sending it, maybe it is my OCD (theory A) suggesting this, and maybe I should experiment more what theory B says and see how this works*

Digging down to the bottom line.

When working with Theory A and Theory B, an additional important reflection to include in the process is:

Theory A	Theory B
What does this say about me as a person?	**What does this say about me as a person?**

As we have previously seen, core beliefs present as fundamental beliefs about the self, others/the world and the future.

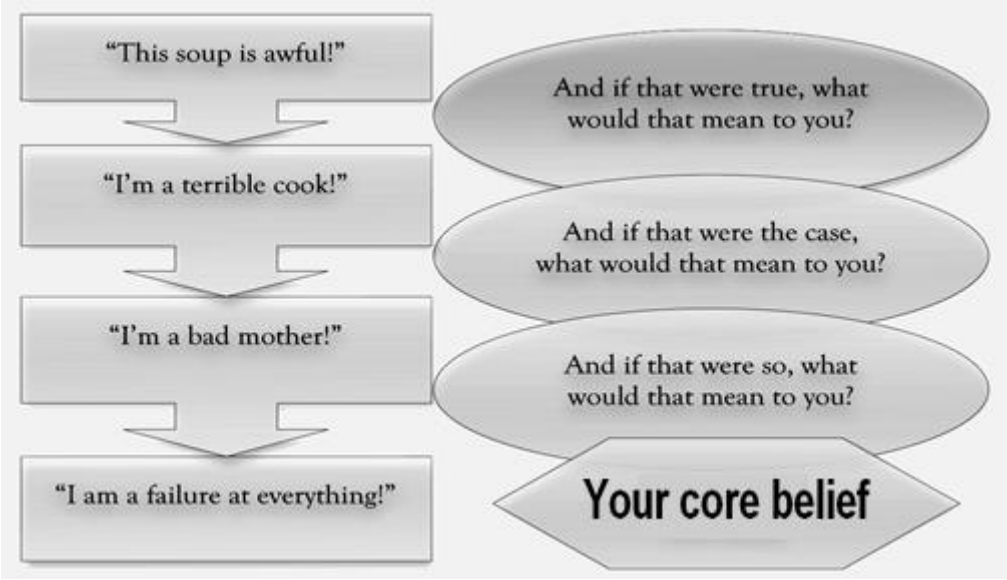
To benefit maximally from treatment, it is important that negative beliefs and core fears are identified and addressed.

Negative core beliefs can partially explain why OCD symptoms are developed and/or maintained.

Therapy will help to identify these beliefs and fears, which in turn will allow you to challenge them using the techniques you are learning in treatment.

Let's look at a couple of examples.

Generic example:



OCD example:

Client: If I don't pray, my husband will have an accident (overestimation of danger) *Therapist: If that were true, what would it mean to you?* *Client: It would be my fault (inflated responsibility; "I am responsible" =* ***core belief****)* *Therapist: If that were true, what would it mean to you?* *Client: I could never forgive myself (black and white thinking). I would be a failure as a wife ("I am a failure" =* ***core belief****)* *Therapist: If that were true, what would it mean to you?* *Client: I would become depressed and harm myself (perceived consequences of responsibility)* *Therapist: We have now identified the* ***core fear****.*

You can try to complete the downward arrow form below to get to your core fear and core beliefs. Remember, these fears and beliefs express how you feel about yourself, others, the world, the future or about situations, but this does NOT mean that they are true or an accurate reflection of reality.

Appraisal
If that were true, what would it mean to me?
If that were true, what would it mean to me?
If that were true, what would it mean to me?
If that were true, what would it mean to me?
If that were true, what would it mean to me?

Week 9 – Task 1: Theory A and Theory B

First, address your OCD problem by: constructing an alternative theory, looking for evidence, establishing what you would need to do and what the theories would say about you as a person.

Theory A	Theory B
The problem is…	**The problem is WORRY (and ANXIETY) that…**
Evidence:	**Evidence:**
What do I need to do if Theory A is true?	**What do I need to do if Theory B is true?**
What does this say about me as a person?	**What does this say about me as a person?**

Week 9 – Task 2: Behavioural Experiments

Once you have constructed and explored Theory A and Theory B, set up a few behavioural experiments to test either Theory B or both theories against each other.

Situation/ Experiment	Negative prediction – Rate strength 1-100% What is the consequence that I fear?	Alternative positive prediction – Rate strength 1-100%	Outcome – What happened? Did my negative prediction come true?	What did I learn?

Week 10 – Responsibility, Guilt, Shame and Blame

The role of responsibility.

Key factors in the maintenance of OCD are:

- The overestimation of the importance of the intrusive thoughts
- The overestimation of the importance of the **control** over the intrusive thoughts
- The overestimation of responsibility

Many compulsions – e.g. focused on checking or contamination - are based on **inflated ideas of responsibility**.

This is an overestimation of how we are actually responsible for events, situations, negative outcomes as well as for our or other people's safety.

One interesting observation is that, when people who have very extreme problems with cleaning and checking go into a residential unit, for the first few days or weeks all their rituals usually stop. Then over a period of a few days, they gradually resume. Can you guess why that is?

Let's have a look at how we can challenge an inflated idea of responsibility.

One way of doing this is the pie chart of responsibility.

We often blame ourselves for something that has happened or for some feared future event that might happen. However, we usually give ourselves more than our fair share of that blame and responsibility.

This "Responsibility Pie" is one way of challenging that distorted thinking to understand that all negative situations can be said to occur as a result of the combination of three factors:

- Our actions: how much does/did my behaviour contribute to the situation (me)?
- The action of others: how much does/did the behaviour of others contribute to the situation (others)?
- Random unpredictable factors

- Write down how responsible you feel or would feel for a situation or event, using a percentage scale with 0% being not at all responsible, and 100% being totally responsible
- Then, think about and write down all the other factors that may contribute/may have contributed to this event, using a percentage scale for each of them
- Now draw lines out to the circle from the centre and mark off sections for each factor, proportionately to how responsible that factor would be
- Finally, include your part in the pie, according to what % of responsibility is left

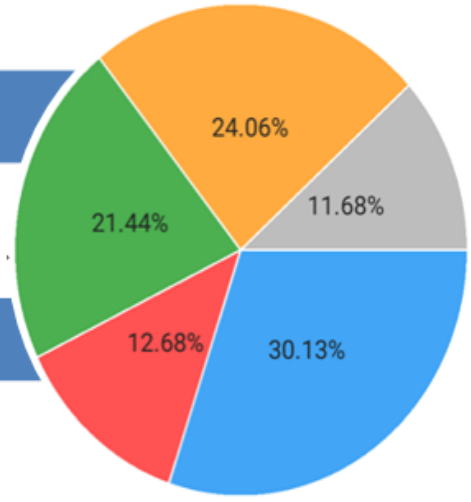
night-time (poor visibility)
+ slippery roads
+ other driver (had 2 glasses of wine)
+ the wine
+ Me
= Responsibility for a car accident

Responsibility Pie Chart

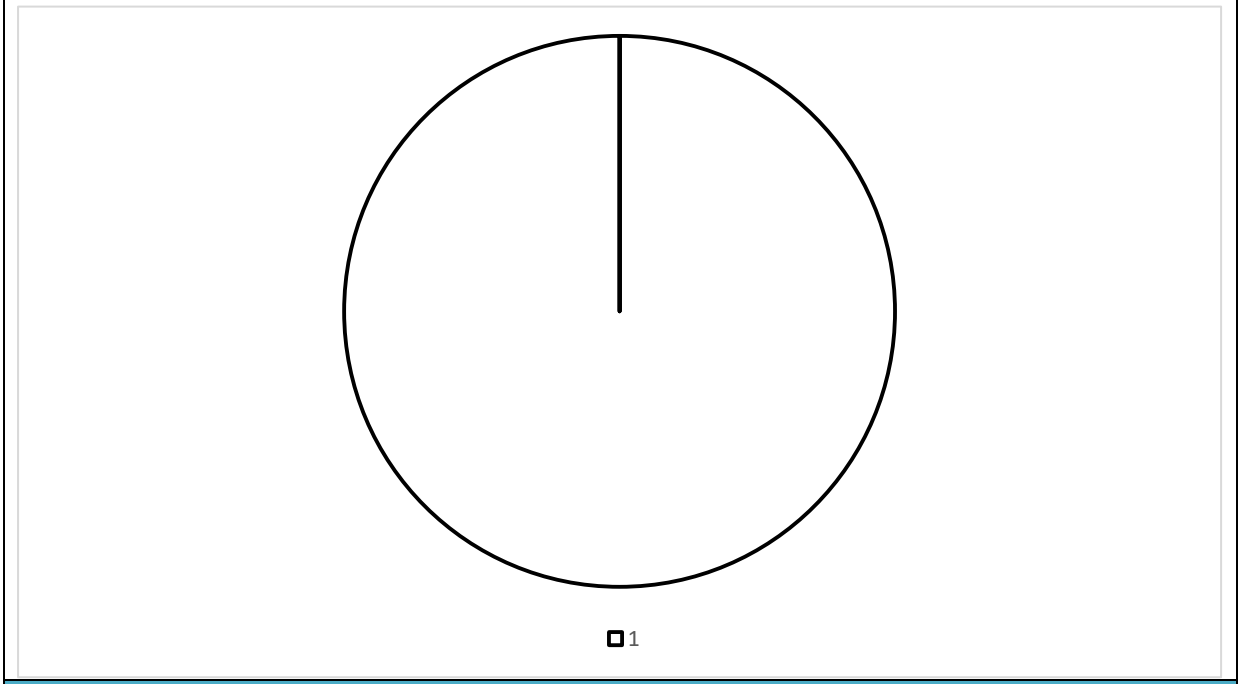
1: Identify the area of responsibility

2. Rate strength of belief (0-100%)

3. List all the possible causes



4. Re-rate belief

Identify area of responsibility: Rate strength of belief about your responsibility: %
List all the possible causes and other factors that might be responsible – rate strength for each one (%):

Re-rate initial belief about your responsibility: %

- The part you are left with (if any) is how responsible you REALLY might be!

The "Third Party Test".

It's often helpful to ask yourself what you would do if you saw this situation from someone else's perspective, for example a good friend of the person with OCD.

This is a good way of challenging the perceived consequences of having been responsible.

For example:

Sandra is a mother who has contamination OCD.
She worries about her child getting a bacterial infection, and if her daughter does get sick, she blames herself, and she also fears that her friends will criticize and condemn her and not allow their children to play with hers.

- How would you judge this mother if her daughter got a bacterial infection?
- Would you condemn a friend if this happened to them?

The Vicious Cycle of Aggression, Guilt, and Disappointment

Many people with OCD symptoms tend to have pent-up anger - often fuelled by their high moral standards - for both themselves and the surrounding world, but also by shyness and difficulties being assertive.

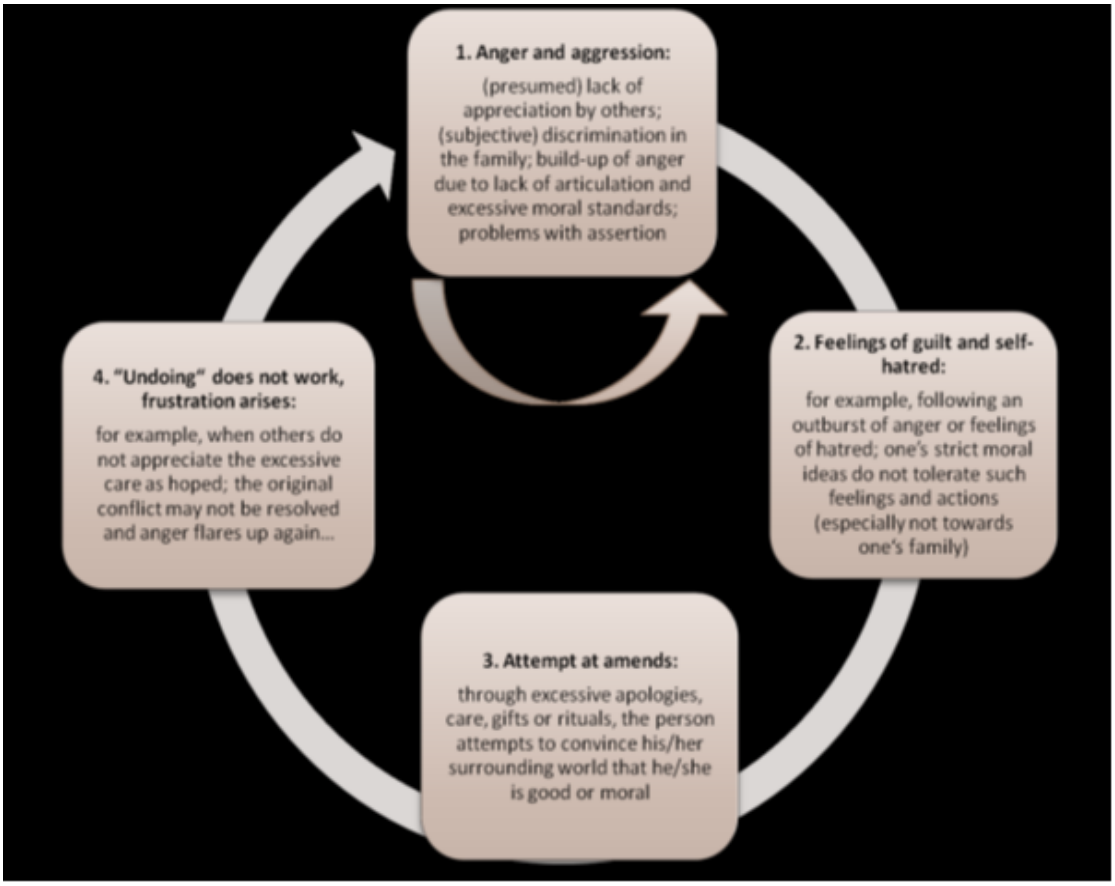
On the one hand, in psychological studies, it appears that they tend to agree more frequently than other people with statements like:

- *"I often have feelings of hatred toward people whom I actually should love."*
- *"I do not feel as close to my friends/relatives as I act on the outside."* (latent aggression)

On the other hand, they also frequently affirm the following statements:

- *"I am frequently worried about the well-being of my friends."*
- *"I have feelings of guilt if I forgot to forward a message to a friend."*

These conflicting feelings usually become more intense during the course of the OCD and can turn into a vicious cycle.



This cycle can be a result of:

Frequent and intense self-critical thinking
An inflated sense of responsibility
High moral standards

One way to challenge these ideas and negative beliefs, is to identify the unhelpful thinking habits that we might be applying to a situation – as we did in previous sessions – and try to replace the negative perspectives with an alternative, more balanced, realistic and positive view:

Situation:	**Thought:**	**Unhelpful thinking habit:**	**Alternative Perspective**
This morning I argued with my wife. *When I left to go to work, I thought that I hated her.*	*I am a bad person and a horrible husband.* *How can I hate my own wife?*	*Self-critical thinking* *Black and white thinking*	*I was just angry, and I was thinking through the filter of anger.* *Every person sometimes feels angry and has bad thoughts, but this does not mean that they really mean what is going through their mind.* *I only thought it, I didn't say this to her nor to anyone else, because I did not want to upset her; this proves that I am a sensible person and a caring husband.*

Can you think about a similar situation or common situations in which you have felt anger followed by guilt and disappointment?

Situation:	**Thought:**	**Unhelpful thinking habit:**	**Alternative Perspective**

Shame and blame

Shame is defined as “an intense negative emotion when you believe you fall short of your idea, such as a flaw or weakness being revealed other others”.

Many people with difficulties related to OCD can feel shame about their symptoms. However, in therapy we talk about shame as a “therapy blocking emotion” because it is much harder to change if you also feel shame.

For example, exposure will be more difficult when shame remains the predominant emotion. In these cases, we need to take a different approach based on compassion.

A key idea here is to imagine that you have been asked to look after your 11-year old niece or nephew; they are a bit apprehensive about coming to stay and you want to make them feel comfortable, but then they do something about which you need to talk to them – maybe walking into your house with muddy shoes: what do you say? What voice do you use?

If you speak to them gently and respectively, then you are using a compassionate approach – one which you could use with yourself.

We are often compassionate to other people, but critical of ourselves, which can increase feelings of guilt, shame, anger towards ourselves and low mood.

When you are having a difficult time, you need support and encouragement to get through it. However, people often judge themselves harshly, reporting self–critical thoughts such as "*I am not good enough*", "*I am not the person I used to be*", "*I should be over it by now*", "*I am weak*". These thoughts affect your emotions and behaviour. Learning to be more compassionate towards yourself can help you in your recovery.

Compare the Critical Voice and the Compassionate Voice.
Notice your inner self-critical voice. Note down the things that it says to you. Notice the tone of this voice - is it judging, cold, angry?
Practice writing down compassionate responses to these criticisms - this is difficult to begin with so keep practicing. Imagine a trusted and kind friend, family member or colleague. It could be someone you know now, or knew in the past, or even a historical or fictional character. If you have trouble thinking of someone, you could use a famous person, character or religious figure, who you believe to be kind, compassionate, fair and gentle.

Ask yourself:

- What advice would I give to a friend I deeply care about who was thinking and feeling this way?
- What does the compassionate part of me want to say to the self-critical part?
- What are some other ways of viewing this situation that might be more realistic, kinder or more helpful to me?
- How will I feel about this in a week, or in a month or a year? If it won't matter much then, can I let go of it now?
- What can I do to cope and look after myself now?

Critical Voice	Compassionate Response
e.g. "I should have done better"	*e.g. "It is easy to look back now and wish things had been different, but this will just make me feel worse. Most people in my position would have done the same, it is not my fault. People make mistakes all the time".*

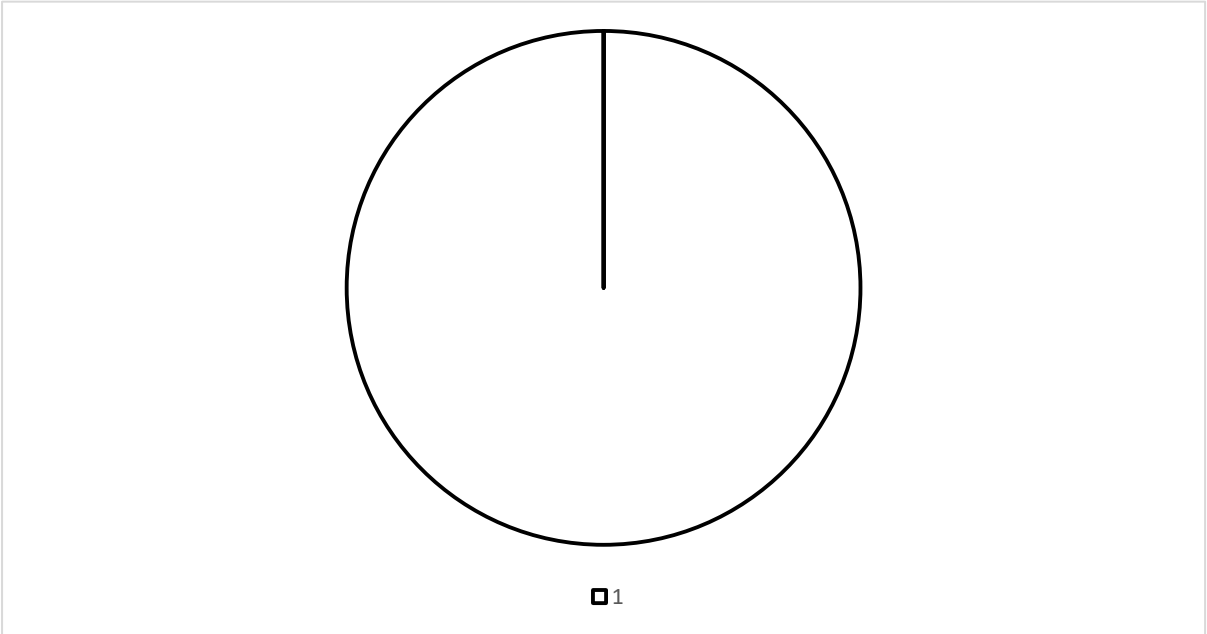
Week 10 – Task 1: Responsibility Pie

Write down how responsible you feel or would feel for a situation or event, using a percentage scale with 0% being not at all responsible, and 100% being totally responsible.

Now think about and write down all the other factors that may contribute or may have contributed to this event, using a percentage scale (%) for each of them.

Then draw lines out to the circle from the centre and mark off sections for each factor, proportionately to how responsible that factor would be.

The part you are left with (if any) is how responsible you REALLY might be.

My responsibility: %
List all the possible causes and other factors that might be responsible – rate strength for each one (%):

Re-rate initial belief about your responsibility: %

Week 10 – Task 2: Alternative Perspective

Considering situations in which you experience thoughts of Responsibility, Guilt, Shame and Blame, use the table below to identify unhelpful thinking habits and challenge the negative thoughts by replacing them with alternative, more balanced and positive perspectives:

Situation:	**Thought:**	**Unhelpful thinking habit:**	**Alternative Perspective**

Week 10 – Task 3: Inner Compassionate Voice

Compare the Critical Voice and the Compassionate Voice.

Notice your inner self-critical voice. Note down the things that it says to you. Notice the tone of this voice - is it judging, cold, angry?
Practice writing down compassionate responses to these criticisms - this is difficult to begin with so keep practicing. Imagine a trusted and kind friend, family member or colleague. It could be someone you know now, or knew in the past, or even a historical or fictional character. If you have trouble thinking of someone, you could use a famous person, character or religious figure, who you believe to be kind, compassionate, fair and gentle.

Ask yourself:

- What advice would I give to a friend I deeply care about who was thinking and feeling this way?
- What does the compassionate part of me want to say to the self-critical part?
- What are some other ways of viewing this situation that might be more realistic, kinder or more helpful to me?
- How will I feel about this in a week, or in a month or a year? If it won't matter much then, can I let go of it now?
- What can I do to cope and look after myself now?

Critical Voice	Compassionate Response

Week 11 – Relapse Prevention

"The strategies that have helped you to get better, will help you to stay well'

As the group draws to a close, it is important that you learn to become **your own therapist**. In order to do this, you will need to take on a number of different roles.

You will need to:

✓ Monitor your OCD
✓ Assign yourself tasks
✓ Carry them out
✓ Monitor your progress

For example, you can:

- ✓ Work on correcting your beliefs about OCD
- ✓ Apply strategies like Exposure and Response Prevention and relaxation skills to situations that come up in your daily life, as well as continuing to push yourself up your hierarchy of fears
- ✓ Identify your unhelpful thinking habits and challenge your negative thoughts
- ✓ Construct Theory A and Theory B and look for evidence
- ✓ Set up behavioural experiments

Being your own therapist will also mean regularly evaluating your method of reacting to difficult trigger situations, encouraging yourself to persevere, even when things get tough, and congratulating yourself on all your successes, both large and small.

It is important to have realistic expectations. The end of the group will probably not mean being OCD anxiety-free (very few people in the population are in this group), but rather having a set of skills with which to address the symptoms of OCD.

The ultimate goal of daily maintenance is that the skills learnt in therapy become automatic, but this requires practise over time.

There are four key areas to think about:

1. **Daily maintenance:** You will need to set aside time, ideally about 15 minutes each day, to keep on top of your skills. We sometimes call this time the 'self-session'.

It is about doing all the things we would do in the group together, with one difference: you are on your own.

The first thing to do is "check in": how am I feeling today?

Then you can try to identify all the situations in the week when you experienced OCD related anxiety.

Draw out your formulation and use it whenever you work with CBT tasks.

Ask yourself the following questions:

- *Where was I?*
- *What was happening?*
- *What thoughts or images went through my mind?*
- *What did that say about me? And about others?*
- *What changes did I notice in my body?*
- *What were my safety seeking behaviours?*

2. **Identifying "at risk" situations:** everyone will encounter times in their lives when there are more stressors, and hence more worries: changes in the work routine; instability in housing; a build-up of debt and ill health are all common stressors. It is important to recognise that everyone will encounter such "ups and downs".

If, during such a stressful period, thoughts such as: "*This is a catastrophe, it's all coming back, treatment didn't work, I've gone backwards"* emerge, these need to be challenged.

Experiencing a period of greater anxiety should not be viewed as a failure or relapse; rather it is an opportunity to continue practising the skills learnt in the group, that in the long-term will give protection against OCD.

Additionally, whenever you experience a setback, it is very important to make sense of what happened, so that you can learn something more from it.

3. **A lapse is not a relapse:** everyone has ups and downs. A lapse is part of the normal fluctuations caused by life, while a relapse would be a return to the level of problems encountered before starting therapy.

4. <u>What you do at home will have a big influence on longer term outcomes</u>.

Here is a checklist to keep in mind:

✓	Make a list in the next few days of areas where you've made improvement
✓	Think about the strategies that got you there
✓	Keep practising new skills
✓	Keep setting new goals to keep challenging yourself
✓	Remember you have to keep "goal persistent" even in the face of anxiety
✓	Identify unrealistic expectations, such as "*I'll never use a ritual again"*
✓	Remember that other stressors in life will cause all anxiety to go up and down
✓	De-catastrophise lapses: it's not "*all coming back*"
✓	A lapse is an opportunity to learn about triggers and to practise or modify new skills
✓	Keep a written record at home of potentially problematic situations, and how, with the new skills that you have learnt, you can cope with these

Finally remember that some OCD related anxiety is a normal part of everyday life – for every person!

Now, take a few moments to reflect on what situations, life events, problems can be considered stressors that can potentially become risk factor for lapse or relapse (e.g. working too much, divorce, poor physical health, etc.):

Therapy blueprint and relapse prevention

A therapy blueprint is a bullet point list of the strategies and techniques that have most helped during therapy.

A maintenance plan or relapse prevention plan is a grid, like the one in the following pages, with the things that you need to do to maintain the gains that you have made in therapy.

You now have the tools to continue to help yourself in these next several months.

Research shows that people treated with Cognitive-Behavioural Therapy generally maintain their treatment gains and in fact continue to show improvement in the months subsequent to the end of treatment.

Do not expect that your progress will continue to be a straight course - expect that there will be ups and downs in the coming months. It is important to distinguish between a lapse and a relapse.

A lapse is not a relapse!

A lapse is a temporary period during which some of the OCD behaviours return. A lapse does not necessarily indicate a relapse. Just because you begin checking or counting does NOT mean that you will return to where you were before treatment.

A temporary return of your OCD symptoms may be a sign that something stressful may be going on in your life.

More importantly, review the strategies and techniques that were helpful in the past. Begin with self-monitoring of intrusions and appraisals. Are the appraisals faulty? If so, what techniques were useful in the past to challenge these techniques?

Conduct specific behavioural experiments with testable predictions and ERP.

Continue to challenge yourself until the faulty appraisals are replaced with more adaptive appraisals that are based on evidence gained through the behavioural experiments and thought challenging.

If you have been prescribed medications please do not come off your medications too quickly or all at once - it may precipitate a relapse or an episode of depression.

Please review your medication with your GP.

At this point, as we are approaching the end, take some time to ask yourself: is there any part of theory or any skills and techniques that you would like to review or ask about?

You might take note of this and ask the facilitators of the course for clarification:

Week 11 – Task 1: Blueprint - My personal Maintenance Plan part 1:

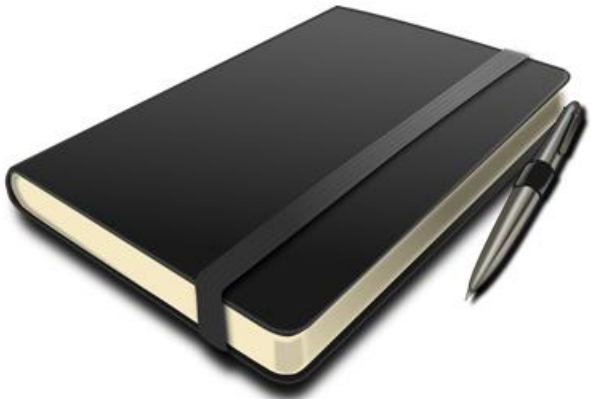
What I have learnt during these sessions? What developed the problem (early experiences leading to core beliefs)? What maintained the problem (vicious cycles- e.g. of thoughts, feelings and behaviour)?
What changes have I made? What am I doing differently?
What was most useful? What techniques have been helpful? How often and when do I need to practise them?
What behaviours are not helpful?
What would be some early warning signs of a relapse? Thoughts/Images-Emotions-Behaviours-Physical Sensations? What events/situations/triggers might cause me to be more vulnerable/at risk?
How will I deal with these difficulties? What can I do to avoid losing control? **What could I do if I lose control?** What support/resources can I use to help me?
What are my therapy GOALS for the next 3 months?

Week 11 – Task 2: Blueprint - My personal Maintenance Plan part 2 - Complete only in case of a lapse/setback:

How can I make sense of this? What events/triggers led up to this setback?
How did I react to this? What did I do? What did I think? What did I feel?
What have I learnt from it? Was this a high-risk situation? Are there things that I can identify are difficult? What helped and what didn't?
With hindsight, what would I do differently? When I think/feel …… what could I do instead?

Week 12 – Review and Evaluation

How did you get on with your relapse prevention plan?



Now that we have come to the end of the group, how do you feel?

Remember that the end of the group is just the beginning of you being **your own therapist**.

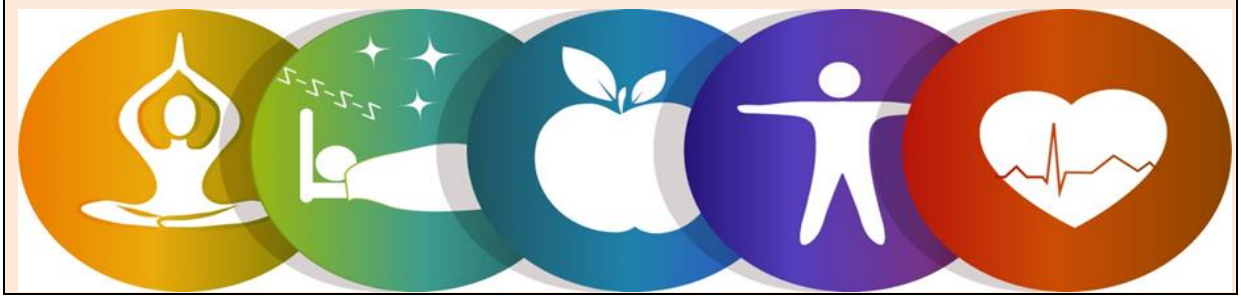
This is what we have covered in our 12-week "Coping with OCD" course:

- ✓ **Week 1 – Cognitive-Behavioural Therapy and OCD**
- ✓ **Week 2 – Understanding Anxiety**
- ✓ **Week 3 – Anxiety & Relaxation Skills**
- ✓ **Week 4 – Exposure and Response Prevention (part 1)**
- ✓ **Week 5 – Exposure and Response Prevention (part 2)**
- ✓ **Week 6 – Negative Thinking (part 1)**
- ✓ **Week 7 – Negative Thinking (part 2)**
- ✓ **Week 8 – An OCD Formulation**
- ✓ **Week 9 – Challenging negative thoughts**
- ✓ **Week 10 – Responsibility, Guilt, Shame and Blame**
- ✓ **Week 11 – Relapse Prevention**
- ✓ **Week 12 – Review and Evaluation**

It will be important to review all these topics and keep practising the theory, skills and techniques covered during our sessions.

It will be also important to make sure that your stress level is not getting too high.

Take some time to think about: what keeps you healthy and less stressed?



One way to try to re-think about your routines is by looking at the Healthy Mind Platter:

The Healthy Mind Platter has seven daily essential mental activities necessary for optimum mental health. These seven daily activities make up the full set of “mental nutrients” that your brain and relationships need to function at their best. By engaging every day in each of these servings, you promote integration in your life and enable your brain to coordinate and balance its activities. These essential mental activities strengthen your brain's internal connections and your connections with other people and the world around you.

We are not suggesting specific amounts of time for this recipe for a healthy mind, as each individual is different, and our needs change over time too. The point is to become aware of the full spectrum of essential mental activities, and as with essential nutrients, make sure that at least every day we are bringing the right ingredients into our mental diet, even if for just a bit of time. Just as you wouldn't eat only pizza every day, we shouldn't just live on focus time alone with little time for sleep. The key is balancing the day with each of these essential mental activities.

One way to use the platter idea is to map out an average day and see what amounts of time you spend in each essential mental activity. Like a balanced diet, there are many combinations that can work well. In short, it is important to eat well, and we applaud the new healthy eating plate.

Seven daily essential mental activities to optimize brain matter and create well-being:

Focus Time
When we closely focus on tasks in a goal-oriented way, we take on challenges that make deep connections in the brain.

Play Time
When we allow ourselves to be spontaneous or creative, playfully enjoying novel experiences, we help make new connections in the brain.

Connecting Time
When we connect with other people, ideally in person, and when we take time to appreciate our connection to the natural world around us, we activate and reinforce the brain's relational circuitry.

Physical Time
When we move our bodies, aerobically if medically possible, we strengthen the brain in many ways.

Time In
When we quietly reflect internally, focusing on sensations, images, feelings and thoughts, we help to better integrate the brain.

Down Time
When we are non-focused, without any specific goal, and let our mind wander or simply relax, we help the brain recharge.

Sleep Time
When we give the brain the rest it needs, we consolidate learning and recover from the experiences of the day.

After the course:

We'd like to remind you about:

LITTLE STEPS & STEPS TOGETHER

Little Steps and Steps Together are peer support social groups for people who have used the Steps to Wellbeing service. They meet fortnightly. Little Steps is based in Southampton, Steps Together in Dorset.

The agenda is set by the members, although there is a staff member from our Peer Support Team present to help organise things. Topics of discussion are focused on mutual support. It's a great opportunity to continue to practise your skills, as well as to meet new people. You don't need an appointment, and there is no fixed number of sessions. Just turn up when you want to.

If you are interested, please contact: dhc.little.steps@nhs.net (Little Steps) or dhc.s2w.dorsetpsps@nhs.net (Dorset)

Useful books:

Challacombe, F., Oldfield, V. B., & Salkovskis, P. M. (2011). **Break Free From OCD: overcoming obsessive compulsive disorder with CBT**. Random House.
Hershfield, J. and Corby, T. (2014). **Mindfulness Workbook for OCD: A Guide to Overcoming Obsessions and Compulsions Using Mindfulness and Cognitive Behavioural Therapy**. New Harbinger Self-Help Workbooks.
Hyman, B. M., & Pedrick, C. (2010). **The OCD workbook: Your guide to breaking free from obsessive-compulsive disorder**. New Harbinger Publications.
Veale, D. & Willson, R. (2009). **Overcoming Obsessive Compulsive Disorder: A Self-Help Guide using Cognitive Behavioural Techniques**. London: Constable and Robinson.

Useful websites for relaxation:

http://wellbeing-glasgow.org.uk/audio-resources/

Useful Contacts and Links:

https://www.ocdaction.org.uk/

http://www.getselfhelp.co.uk

https://www.ocduk.org/

https://dorsetocd.wixsite.com/supportgroup

We hope you've enjoyed the course…

… keep on practising and good luck!

Contact Details
General: dhc.steps2wellbeing@nhs.net
Southampton: Telephone for self-referrals: 0800 612 7000; Telephone for information and cancellations: 02380 272000; dhc.sstw@nhs.net
Bournemouth or Christchurch: 0300 790 0542; dhc.bc.s2w@nhs.net
Poole: 0300 123 1120; dhc.pped.s2w@nhs.net
Purbeck or East Dorset: 0300 123 1120; dhc.pped.s2w@nhs.net
Weymouth, Portland, Mid or North Dorset: 0300 790 6828; dhc.west.admin.s2w@nhs.net

Dorset HealthCare University NHS Foundation Trust

steps 2 wellbeing