CHAPTER 4

Cognitive Behavioral Therapy for OCD: Introduction to the Self-Directed Program

There are risks and costs to a program of action, but they are far less than the long-range risks and costs of comfortable inaction.

—John F. Kennedy

This chapter introduces the self-directed program for breaking free from OCD. The program is grounded in the principles of cognitive behavioral therapy. As mentioned in the previous chapter, CBT differs from traditional talk therapies, which tend to focus on events from the past that may have contributed to current symptoms. In CBT, the focus of treatment is on the present, and specifically on identifying and changing beliefs, thought patterns, and behaviors that currently maintain symptoms. As discussed, a key approach in CBT is exposure and response prevention, which is widely considered to be the gold standard of cognitive behavioral treatment for OCD. Almost thirty years of research, as well as the

testimony of thousands of people with OCD, indicate that ERP is a highly effective intervention for reducing OCD symptoms.

ERP consists of two parts: exposure to feared situations with accompanying thoughts, feelings, images and urges; and response prevention, or voluntarily blocking compulsive behaviors. While that may sound simple, it actually involves hard work and a high degree of commitment. It also requires courage, because the images, impulses, and fears associated with OCD seem so real and vivid. The compulsive urges and rituals are so powerful and so persistent that the prospect of change may appear downright terrifying to you. This is to be expected. If you didn't feel this way, you wouldn't have OCD.

WHY ERP WORKS

Exposure and response prevention is based in part on the principle, well-established by scientific research, that we can overcome fear by daring to face the objects or situations that cause anxiety, dread, and avoidance. Exposure relies on two important and related learning processes: habituation and extinction.

Habituation

As mentioned in chapter 3, habituation is the natural tendency of the nervous system to numb out to stimuli through repeated, prolonged contact with a novel stimulus. It has also been referred to as "the remedy of nervous system boredom" (Ciarrocchi 1995, 76). We all experience the process of habituation in our daily lives. In chapter 3 we presented the example of the jolting chill you feel upon diving into a pool of cold water. But after a few minutes, the natural process of habituation enables you to no longer feel the chill of the water.

Exposure and response prevention treatment utilizes this same process of habituation to help you systematically overcome feelings of fear and dread in situations involving people (the homeless, for example), places (such as airplanes), and, in the case of OCD, even fears of your own thoughts. Through frequent and prolonged confrontation with situations you fear and dread, your nervous system will automatically numb out fear responses, bringing them down to more manageable levels.

Here's a simple example of how habituation works to help overcome fear, in this case the irrational fear, or phobia, of water: The fearful individual first approaches the edge of a swimming pool until his or her fear rises to uncomfortable levels, perhaps several feet away, and then waits there. Over the next several minutes, the person's original fear gives way, numbing out as nervous system habituation kicks in. When calm, the person then moves closer to the pool, perhaps a few inches away, until the fear once again rises to uncomfortable levels. Again, the person waits until habituation causes the feelings of dread to diminish to manageable levels. The process is repeated in baby steps. Gradually one toe is placed in the pool, then a foot, then both feet, then the legs up to the ankles, and then the legs up to the knees. Then both legs are entirely immersed, and gradually the whole body is immersed with very little fear. Although this example is simplified, the process of overcoming OCD-related fears takes place in a similar manner. In order for this approach to be effective, it's also necessary to practice response prevention, in other words, to refrain from engaging in compulsive behaviors or responses.

Extinction

Exposure and response prevention is also founded on the basic principle of learning known as extinction. To understand extinction, we need to take a step back and look at how behavior develops. All behavior—that which you can see, such as eating and driving to work, as well as behavior you can't see, such as thinking and feeling—is governed by its consequences. Consequences shape our behavior. They are either positive, such as praise, hugs, paychecks, delicious flavors, enticing aromas, pleasant feelings, or attention from someone important to us, or negative, such as punishment, criticism, embarrassment, parking tickets, fines, or jail. Positive consequences are also known as reinforcers.

Reinforcers work by bringing about feelings of pleasure and satisfaction or by reducing or preventing unpleasant feelings or experiences, such as hunger, pain, or tension. Behaviors such as eating, drinking alcohol, or watching TV as an escape are considered reinforcers when they reduce discomfort or unpleasantness. Reinforcers influence all of our behavior either by increasing feelings of pleasure and comfort or by decreasing discomfort, uncertainty, pain, or tension.

Extinction is what happens when a reinforcer no longer brings about feelings of pleasure or no longer reduces tension or discomfort. Think of the many behaviors you engage in that are reinforced or rewarded: working hard for a paycheck or a bonus, buying flowers for a smile or hug from a loved one, playing your favorite sport for fun or relaxation, and so on. Now, think of what might happen if these same behaviors, for whatever reason, no longer brought the reinforcement you want or seek: your bonus is cut despite your hard work, your loved one no longer smiles or gives you a hug when you bring flowers, or your favorite sport is no longer fun or relaxing. Usually, the result is that these behaviors become *extinguished*—you stop doing them with the same vigor, and eventually you may stop doing them altogether.

Given that behavior is governed by its consequences, it isn't hard to see how compulsive rituals—hand washing, checking, and ordering, for example—strengthen or reinforce obsessive worries and fears. Compulsive rituals reinforce obsessions and worries by reducing, at least temporarily, the tension, worry, and anxiety associated with obsessive thoughts and feelings. In exposure and response prevention, response prevention in the form of refraining from rituals reduces obsessive worries by means of extinction. When you block behaviors that reinforce worries and keep them going, obsessional worries eventually diminish.

EXPOSURE IN VIVO

In vivo means "in life." In terms of exposure, it's used to mean prolonged face-to-face confrontation with anxiety-evoking situations, objects, thoughts, or images in real-life contexts. Here are some examples of in vivo exposures for different types of OCD problems:

- **Washing:** Touching a "contaminated" object, person, or place and not washing afterward.
- **Checking:** Turning off lights, stoves, and appliances only once, or slowly driving a car through an area where small children play and not turning around to check, despite powerful feelings that the car hit a child.

- **Ordering:** Leaving household objects "imperfect" (slightly messy, off-center, or not at right angles), without straightening, balancing, or correcting anything.
- **Primarily obsessional OCD:** Purposely thinking distressing thoughts by writing them down over and over or listening to them on a tape, without avoiding or counteracting these thoughts; simply allowing them to be there.

In order to be effective, in vivo exposure must follow two important rules: It must purposefully and vividly reenact situations that provoke fear, dread, doubt, and avoidance. And it must be prolonged, lasting as long as it takes for the anxious feeling to diminish through habituation. It could take anywhere from a few minutes to several hours before the anxiety reaches tolerable levels.

Exposure changes the way you appraise or interpret danger and harm in specific situations. Recall the analogy presented earlier: diving into a pool of cold water. Your brain and central nervous system naturally adapt (or habituate) to the unpleasant sensations within a few minutes, without you having to do anything about it. The water in the swimming pool doesn't change, your brain's interpretation of the temperature of the water changes. When you do effective exposure, you give your brain the chance to *reinterpret* or *reappraise* OCD's messages. Here are a few examples.

OCD thought		Reinterpreted thought
"It is extremely dangerous to do (touch, think) this."	*Becomes*	"Nothing terrible will happen if I do this. I can take a chance."
"I must do this many times."	*Becomes*	"I can do it just once, and that's okay."
"I must be evil to think such a bad thought."	*Becomes*	"It's just one of those silly OCD thoughts."
"I must turn around to make sure no one was hurt."	*Becomes*	"If I turn around, I'm just going to make my OCD worse."

Keep in mind that some fears involve catastrophes that are impractical to simulate in vivo. Feared situations that may occur in the distant future, such as getting seriously ill or dying can't be easily simulated. Other fears are either too complex to confront in vivo or simply too impractical to reenact in vivo alone. These can include fears of causing someone's illness or death or going to jail for doing something illegal or immoral. In these situations, imaginal exposure is useful. In this technique, you imagine or vividly bring to mind the feared situation for a prolonged period of time. Chapter 7 is devoted to the topic of imaginal exposure.

RESPONSE PREVENTION

For exposure to be effective, it is necessary to eliminate, block, or sharply limit all behaviors that neutralize or lessen the feelings of anxiety and discomfort brought about by obsessions. Response prevention refers to the supervised or self-controlled blocking of the compulsive rituals that lessen or prevent anxiety and discomfort. Simply put, response prevention means preventing yourself from performing your usual rituals. Once the ritual is blocked, your brain has the opportunity to provide the natural habituation to the fear-provoking situation. This allows for more realistic and adaptive interpretations of the situations to replace your old, fearful appraisals.

When you block rituals, you are purposefully allowing the anxiety to be present. This allows new adaptations to occur. As with exposure, effective response prevention must be prolonged enough to begin to break down previously acquired associations between anxiety-provoking stimuli and rituals. For example, consider the association between a "contaminated" doorknob and the urge to immediately wash your hands in order to feel safe. Doing response prevention involves the willingness to tolerate initially high levels of discomfort in the face of powerful urges to relieve your tension and fear by engaging in a compulsive ritual, in this case hand washing. Here are some more examples of response prevention:

- Not washing for an entire day (or longer) after touching something "contaminated."
- Not receiving reassurance. For example, you could have your spouse or partner kindly but firmly decline your requests for reassurance about obsessions. Reassurance is often sought for obsessions concerning contamination, safety of others, or having done something immoral or illegal. You will be encouraged to live with your uncertainty and doubt until that gnawing concern subsides on its own.
- Not turning around to check whether you hit someone while driving, despite the sensation of having run over somebody. Instead, you'd allow the fear to rise to uncomfortable levels, then not act upon your urge to check.
- Delaying rechecking that doors are locked or that the stove is turned off (after checking it once) for an agreed upon length of time, say thirty minutes.

Response prevention is one of the key tools you'll learn in the self-directed program. In this approach, you'll make the powerful decision to alter your patterns of rituals in significant ways—by delaying them, shortening them, slowing them down, or eliminating them entirely. This allows you to choose to feel the anxiety, doubt, fear, and dread that you've been avoiding. If doing response prevention doesn't feel at least somewhat uncomfortable, you probably aren't blocking your habitual response enough to make a difference in your OCD. The decision to "feel the discomfort," to just "be with it," or "allow it to be" without acting on it and controlling it will pay off in your progress toward breaking free from the grip of OCD.

Identifying Your Fears About Changing

At the beginning of therapy, a man who had suffered with OCD for forty years vividly described the prospect of confronting his fears and rituals, saying, "It's like being asked to do a swan dive off a five-story building into a bucket of water." Everyone with OCD feels similarly about starting exposure and response prevention, and they often cite similar reasons for fearing making changes. Below, we've listed some of the common fears and concerns we've heard. Check off any that apply to you, and if you have any additional fears and concerns, write them in the space provided. Alternatively, you can write your fears and concerns about changing in your journal:

- ☐ If I don't do my rituals, what will I do instead to feel safe?"
- ☐ If I confront my fear of dirt, germs, AIDS, and the like, how can I be guaranteed that the catastrophe I fear (getting sick, losing a loved one, hurting my children) won't happen?
- ☐ Since there's no cure for OCD, why bother?
- ☐ I know I'll fail. I've failed at everything else.
- ☐ If I fail at this, I'm at the end of the road; there will be nothing left that can help me.
- ☐ If I try this and fail, I'll be considered a loser by everyone who knows me and is pulling for me.
- ☐ I've already done cognitive behavioral therapy, and it didn't work for me.
- ☐ I'd rather just take medication. This is too hard.
- ☐ My rituals are necessary to ward off the dangers I fear.
- ☐ I'm too old to try something different.
- ☐ I'm afraid I'll go crazy (get sick, harm others, and so on) if I'm prevented from doing my rituals.
- ☐ In childhood I was abused (neglected, abandoned, sick, and so on). If it wasn't for my clueless parents (those ignorant teachers, the schoolyard bully, that incompetent doctor, and so on), I wouldn't be in the mess I'm in today!
- ☐ My thoughts are so bad it must mean I have an 'evil seed' inside of me. I don't deserve to get better.
- ☐ If I get better or feel happy, then something bad will surely happen. I don't want to take a chance.
- ☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ Other: _____

As you address your fears about getting started and begin to engage in ERP, you may discover other fears that you didn't note here. Continue adding to the list as you discover other fears. Review your fears and concerns each day until you've dealt with them constructively, or until they no longer bother you significantly. Remember, what's important isn't getting rid of the fear; it's maintaining your freedom and choices in the face of the fear. This is what the self-directed program is designed to do.

DEALING WITH YOUR FEARS ABOUT CHANGING

Now that you've identified the fears and concerns you have about starting the self-directed program, let's look at ways to deal with them.

If I don't do my rituals, what will I do instead to feel safe? Your need to feel perfectly safe is part of your OCD. By taking a chance and not using rituals to deal with your discomfort, you open yourself to other possible ways of handling the discomfort you feel. You are making progress when you take the "risk" of reducing or eliminating rituals.

If I confront my fear of dirt, germs, AIDS, and the like, how can I be guaranteed that the catastrophe I fear won't happen? You can't be guaranteed a life without risk, pain, loss, hurt, error, or injury. The problem is that your brain has made a mistaken connection between your compulsions and feelings of safety and comfort, no matter how temporary those feelings are. ERP can help you break the stranglehold of rituals in your daily life.

Since there's no cure for OCD, why bother? This all-or-nothing way of thinking is typical of people with OCD. Even modest progress can make a significant difference in your quality of life, and your family's quality of life.

I know I'll fail. I've failed at everything else. The only failure would be not trying to succeed by using the self-directed program to improve your life.

If I fail at this, I'm at the end of the road; there will be nothing left that can help me. You are never at the end of the road—ever (until you die). As long as you're breathing, there are always new options to explore, and the search for new and effective treatments is ongoing. You'll never know what the road to recovery is like until you actually travel upon it, putting one foot in front of the other, one step at a time.

If I try this and fail, I'll be considered a loser by everyone who knows me and is pulling for me. Others will judge you by the steadfastness of your commitment to getting better. The specific outcome of your efforts is less important than your dedication to the process.

I've already done cognitive behavioral therapy, and it didn't work for me. Often what people describe as previous experience with cognitive behavioral therapy was actually something other than ERP, such as relaxation training, creative visualization, snapping a rubber band worn around the wrist, hypnosis, or any number of other behavioral techniques, all known to have little or no effectiveness with OCD. And even if you did indeed do expertly conducted ERP treatment in the past without success, a fresh start may yield positive benefits.

I'd rather just take medication. This is too hard. ERP is hard, no doubt about it. And medication definitely plays an important role in the overall treatment of OCD. However, improvement with medication alone is usually limited. In addition, as discussed in chapter 3, some people with OCD simply don't benefit from medications or suffer intolerable side effects. ERP is an important element in optimizing your recovery from OCD. Research evidence indicates that people who have acquired skills such as those offered in the self-directed program suffer fewer problems and are less likely to relapse should they decide, for whatever reason (such as pregnancy or side effects), to discontinue taking OCD medications (O'Sullivan, Noshirvani, and Marks 1991).

My rituals are necessary to ward off the dangers I fear. The degree to which you truly believe, all of the time, that your rituals are necessary—versus knowing at least most of the time that they are dumb, silly, or make no sense—predicts how well you are likely to progress in the self-directed program. If you usually tend to truly believe your rituals are necessary, this is what is known as an overvalued idea. In this case, you may need to address this belief before you start the self-directed program. Turn to chapter 8, Challenging Your Faulty Beliefs, and work through it first, before continuing with this chapter.

I'm too old to try something different. The good news is that treatment for OCD helps no matter when you start. Without treatment, symptoms do tend to get worse with age; however, there is no age group that the self-directed program cannot help.

I'll go crazy (get sick, harm others, and so on) if I don't do my rituals. In over twenty years of working with over a thousand OCD patients, Dr. Hyman has never seen anyone become crazy, sick, or psychotic from ERP. The anxiety experienced during ERP may be uncomfortable, but it is never dangerous. If you find exposure too uncomfortable to do on your own, it's probably best to carry out your ERP with a trained cognitive behavioral therapist who is experienced in the treatment of OCD. The added support and guidance from a trained professional can make all the difference.

In childhood I was abused (neglected, abandoned, sick, and so on). If it wasn't for my clueless parents (those ignorant teachers, the schoolyard bully, that incompetent doctor, and so on), I wouldn't be in the mess I'm in today! Many people with OCD suffered during their childhood. Many people without OCD also suffered in their childhood. The majority of people with OCD have loving,

concerned parents who did the best they could, perhaps while dealing with OCD in themselves or other family members. They had the added disadvantage of having access to so much less information about the disorder, and its treatment, than is available today. Blaming your parents or others from your past for your OCD only serves to maintain the problem. It keeps you stuck in the role of victim, leaving you powerless to combat your OCD in the present. The self-directed program offers you the opportunity to powerfully take charge of your OCD problem *now*.

PREPARING FOR CHANGE

Although we've addressed some of the most common fears associated with ERP, you may have some lingering anxiety about the process itself. This is to be expected. Realize that you won't be stopping all of your OCD rituals at once. Chapters 5 through 7 will lead you through the process step-by-step. Yes, you will experience some anxiety while engaging in ERP, but we think you'll find that the anxiety and distress involved in the process of breaking free is much less than what you experience now, in the grips of OCD. Before you turn to chapter 5, it's important to prepare yourself—and your family and friends—for the challenging but rewarding work ahead. The key is to make breaking free from OCD a priority. Here are some tips to help ensure your success:

- Set aside a period of three to six weeks during which you will make the self-directed program the most important priority in your life.
- Be prepared to spend a minimum of two to three hours per day (not necessarily in one single chunk of time)—every day—doing ERP.
- Tell others in your immediate family what you are embarking on, and if you can, get them solidly behind you. Ask family members to read chapter 18, and be sure they read the "Help for Family and Friends" section just below.
- Find a supportive person in your environment who would be willing to coach you in carrying out the self-directed program.
- This can be a close friend, family member, or therapist. It is vital that this person be knowledgeable about OCD, accepting, and nonjudgmental. This person should also have a sincere interest in helping.
- It isn't necessary to delay starting on medication while you do the self-directed program. In fact, in some cases medication may enhance the effectiveness of the program. Likewise, the program is likely to enhance the effectiveness of your medication regimen.
- Alert any mental health professional you're seeing that you're beginning a self-directed program to reduce your OCD symptoms. You can share this book with your care provider to give him or her information about the program.

HELP FOR FAMILY AND FRIENDS

Living with someone who has OCD is frequently painful, baffling, and frustrating. The disorder can challenge the patience and compassion of even the most benevolent family members. Although most loved ones wish only the best for the person with OCD, over the years deep anger and resentment toward the person with OCD may have developed. Negative feelings that aren't acknowledged and managed effectively can be destructive to the recovery process. For a detailed discussion of these issues and how to deal with them, see chapter 18.

Informed and compassionate family involvement is vital to the recovery process. In order to be successful in combating OCD, your loved one will need your support and cooperation. For example, understanding how ERP works—and why—will help you better support your loved one. Reading this book would be helpful. It's also important to understand and confront your own role in perpetuating or enabling the problem by offering reassurance and accommodating the OCD. For example, one way family members perpetuate OCD symptoms is by participating in compulsions in order to keep the peace. The mother who needlessly launders all the family's clothing several times a week to keep her son with OCD comfortably free of "contamination" is, without intending to, contributing to his OCD problem. Such enabling behaviors must eventually be stopped, but it's important to do so gradually and in cooperation with the person with OCD.

You can help your loved one by assisting with the difficult work involved in ERP. Although we aren't proposing that family members function as "junior behavior therapists," you can be helpful in coaching and supporting your loved one's efforts to overcome his or her OCD problem. To be most helpful, you should serve as an encourager, guide, and monitor. To that end, here are some guidelines for providing the most effective support for your loved one:

- Realize that people with OCD cannot control the powerful urges they experience. A chemical imbalance and overheated brain circuitry are ruling their thoughts and behavior. They don't *choose* to have OCD any more than a person chooses to have diabetes or thyroid disease.

- Family members must never force or impose their wishes upon the person with OCD, especially in regard to self-directed treatment. The decision to engage in and follow the self-directed program must be solely the choice of the person with OCD.

- Don't criticize or scold if the person with OCD doesn't fulfill your expectations. Talk about your feelings, but don't blame your disappointment on the person with OCD.

- Do your best to maintain a nonjudgmental attitude. It's especially important that you never judge the person with OCD based on his or her progress (or lack of progress) with the self-directed program.

- Expect relapses and backsliding. Progress is often two steps forward and one step back. Resist any tendency to become discouraged and negative. Stay positive, keep working at it, and the OCD *will* get better!
- Use verbal praise to reward progress, no matter how small and seemingly inconsequential. Even if reducing from fifty to forty checks doesn't seem like a big deal to you, for the person with OCD it may be a major step.
- If the person with OCD is your child or your spouse, stop blaming yourself for the OCD. You didn't cause the OCD. The causes of OCD generally lie in genetic and biological vulnerabilities—factors that are beyond your control. Let go of guilt, as it will only drain you of the energy you need to effectively help your loved one.
- Realize that OCD symptoms typically don't make much sense, and can even be maddeningly inconsistent and unpredictable. Dr. Hyman once had a client who was terrified of germs and lived in constant fear of the possibility of anyone getting saliva on him. But he loved it when, upon arriving home from work, his dog joyously licked his face. That's just the nature of OCD—all too often, it makes no sense.
- Realize that your loved one isn't the OCD. As such, it's best to avoid reading too much into the symptoms. Dr. Hyman recalls a young female patient who considered her father "contaminated" by germs and would therefore avoid any physical contact with him. He read into this pattern that perhaps he was unworthy of his daughter's love despite all the sacrifices he had made to raise her. He took this very hard, and at first he resented his daughter. With counseling from an OCD specialist, he came to understand that the problem was the OCD, not his relationship with his daughter. He realized that the symptoms meant nothing other than "it's just OCD." In time, he was better able to provide emotional support for his daughter in her struggle against the OCD.
- Do your best to help maintain a calm, stable, and consistent environment at home. When OCD symptoms are at high levels, it's especially important to avoid altering daily routines or embarking on major family changes or transitions, even positive ones. Family instability makes OCD worse.