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OVERCOMING OBSESSIVE COMPULSIVE DISORDER

*A self-help guide using
Cognitive Behavioral Techniques*

DAVID VEALE AND
ROB WILLSON

ROBINSON
London

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Important Note

This book is not intended as a substitute for medical advice or treatment. Any person with a condition requiring medical attention should consult a qualified medical practitioner or suitable therapist.

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Table of contents

Acknowledgments	vii
Foreword	ix
Introduction by Professor Peter Cooper	xvii
PART ONE: Understanding Obsessive Compulsive Disorder	1
1 What is obsessive compulsive disorder?	3
2 What caused your obsessive compulsive disorder?	53
PART TWO: Overcoming Obsessive Compulsive Disorder	93
3 Cognitive behavior therapy and self-help for obsessive compulsive disorder	95
4 Overcoming obsessive compulsive disorder: how it actually works	147
5 Getting ready to change	199
6 Taking it step by step	263

7 Keeping obsessive compulsive disorder at bay	273
8 Children and adolescents with obsessive compulsive disorder	285
9 What can family and friends do to help?	301
Appendix 1: Medication for obsessive compulsive disorder	335
Appendix 2: Finding professional help	359
Appendix 3: Support groups, charities, and other resources for obsessive compulsive disorder	371
Appendix 4: Self-assessment forms	379
Appendix 5: Progress charts	431
Index	443

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Foreword

*Obsessive Compulsive Disorder is a solvable problem,
and the solution is in your hands.*

As someone working on a daily basis with Obsessive-Compulsive Disorder (OCD), I know that sufferers, caregivers, and professionals need all the help that they can get, and here it is! This is the book which I have long hoped someone would write to help all of us. It presents an approach closely based on Cognitive Behavior Therapy (CBT), which is the only psychological treatment that has been shown to be effective in OCD. You will find this book clear, practical, focused, and helpful. It will be extremely useful both for those who suffer from OCD and those who care for them. How will it help? At the very least, it will help to improve understanding of this seemingly complicated problem by helping you to understand what OCD is and how it works. As the reader will find out, OCD has its roots in normal thinking. The sufferer is not crazy, bad, or dangerous to know, but is someone who has been trapped by a particular pattern of thinking and reacting. The book

will help you identify the vicious circles which form the basis of the persistence of OCD. For many, a better understanding of how OCD works will allow them to progress to a better understanding of how to deal with it. In this book they will find detailed help with how to begin to do that. For some this book may even show the way to recovery and take them down that path. If it doesn't take you that far, it will at least provide you with a useful map for that journey. And it will help you understand your enemy; your enemy is OCD.

Surely people know that OCD is the problem? Often not. We now know from research that it takes on average seven years from the point where obsessional problems start to interfere with the person's life to the diagnosis being made. And that is just the beginning of trying to get the right treatment. Surely then it is clear what the problem is? Again, often not. It is in the nature of the problem that OCD makes you think that the problem is something else. You feel dirty, unsure, or responsible for harm, and it seems like these feelings reflect the reality. These feelings are not true. If you are a washer, your problem is not dirt. If you are a checker, your problem is not uncertainty. If you fear that you will harm others, your problem is not loss of control. And so on. The problem is *worry* about being contaminated, causing harm, of not being careful enough. In fact, the person suffering from OCD cares so much that they try to deal with the worry about slight risks in ways which are counter-productive and damaging, and which increase and exaggerate their perception of the risk itself. The fears triggered by OCD make the sufferer

try too hard to be clean, to be sure, to keep in control and so on. The solution *becomes* the problem as the person feels unable to ignore their thoughts and doubts because it seems to them to be too risky. It seems paradoxical (but isn't) that OCD is a problem particularly likely to be suffered by people who are especially sensitive or caring. The loving mother has thoughts of harming her children, the person who values cleanliness is tortured by the idea that they are spreading contamination, the careful person fears that they are being careless, the religious person is tortured by apparently blasphemous thoughts and so on. The harder the person with OCD tries to deal with the obsessional ideas the more distressed they become.

How can the solution become the problem and the sufferer not be aware of it? The answer lies in the nature of OCD. Obsessive Compulsive Disorder is many things, none of them good. But it does not always seem that way from the inside. When it starts, it often masquerades as a friend or helper; 'if only you can do a little more, then everything will be fine'; 'it helps me stop worrying'. These ideas are true only in the short term and early in the problem. As time goes on, it begins to be clear that the promises offered by OCD concealed a trap. A quick check becomes several checks, then becomes hours of checking and finally endless checking.

The reality is that OCD is best thought of as being like a bully or blackmailer, progressively demanding and taking more and more, finally forcing the sufferer to obey its every whim, often to the point of total humiliation and subjugation. For some, it can take them to the point

of total desperation where life no longer seems worth living. Whilst most sufferers know how distressing it can be, what is less obvious is the way in which OCD acts like the worst kind of manipulative compulsive liar and cheat. It promises relief if you do things 'just one more time', avoid the next situation and so on. It seems as if resistance is futile, and that only by giving in does the person have any hope of peace of mind or happiness. Nothing could be further from the truth; no one, however hard they tried, has ever become happy through obsessional behavior.

It is very hard indeed for sufferers to gain the perspective they need to break out of the vicious circle of obsessional worry leading to compulsive behaviors (trying too hard to combat their worries through washing, checking, and neutralizing). An outside perspective is vital if the person is to be able to choose to change. In this book, David and Rob have provided some of the insights which can help the person begin to see OCD for what it really is. So will it be enough? Probably not for some, maybe a little for others, but it is a really good start. OCD is allergic to being understood. It seems likely that there are many people in the community who deal with their OCD without professional help. I hope that this book will increase the number of people seeking the advice of professionals.

The fact that some find ways of helping themselves does not mean that everyone can. People suffering from OCD are used to being told that they should 'pull themselves together'. Good advice, but pretty pointless by itself.

There is nothing that a sufferer wants to do more than pull themselves together, and they would have done it a long time ago *if only they had known how to*. This book provides both the background and some of the tools which will help the sufferer begin the process of pulling themselves together, and should also help their caregivers to support them in this task.

How about the caregivers? They don't suffer from OCD, but have to cope with it on a daily basis. Which means that the caregiver in fact also suffers from OCD in an indirect way. Rather like that which happens for the OCD sufferer, their involvement can begin in small ways. They can check things for their loved one (the door, the gas, the electric . . .). They can avoid touching the 'contaminated' object or saying particular things. In this way they are gradually recruited into rituals and can end up behaving as if they were obsessional themselves. Caregivers and sufferers need a different way of thinking about (and talking about) the problems they face together. This book should provide the basis for helping them communicate and focus on what really needs to be done. Both need support in this enterprise, and to find ways of supporting each other in the process of change.

Surely a book can't deal with all these problems? Not on its own of course. But every little helps, and this book provides more than a little. We now know that problems such as OCD are so common that it would still not be nearly enough if all those offering psychological treatment were offering cognitive behavior therapy. The reality is that most psychological therapists do not offer CBT and there

is not enough expert help to go round. To try to deal with this shortfall, professionals are moving towards what is called 'stepped care'. This means that help can be offered at different levels of intensity and expertise, from self-help groups and books at one end through to specialist units with highly skilled CBT professionals at the other. If the less intensive options don't help or don't help enough, then the next step needs to be taken. This book is a marvellous first step, providing the sufferer and their caregivers with a solid foundation for the work which they need to do on their own or with professional help. If it doesn't 'cure' OCD, that's no surprise, because everybody needs something a little bit different. However, the book will also help you work with a CBT therapist if you are able to find a good one.

In my view, cure is possible and if you have OCD your aim should be to free yourself of your problem, using the strategies described in this book. However, remember that achieving that aim doesn't just involve fighting the OCD. It also involves reclaiming your life and taking up your hopes, goals, and dreams rather than being swamped by your fears. You need to be in touch with and working towards what you are fighting for as well as understanding and dealing with what you have to fight against.

In summary I particularly like this book because it offers people suffering from OCD a fighting chance, and that is good news to me for two reasons. First, I detest OCD and what it does to people who suffer from it and their loved ones. Second, I like and admire the people we try to help fight against OCD, and think that they need and deserve

the best possible help in their struggle to overcome this destructive and all-consuming problem. This book will help in that struggle.

Paul Salkovskis
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Disorder and Trauma.

Introduction

Why a cognitive behavioral approach?

Over the past two or three decades there has been something of a revolution in the field of psychological treatment. Freud and his followers had a major impact on the way in which psychological therapy was conceptualized, and psychoanalysis and psychodynamic psychotherapy dominated the field for the first half of the twentieth century. So, long-term treatments were offered that were designed to uncover the childhood roots of personal problems – offered, that is, to those who could afford it. There was some attempt by a few health service practitioners with a public conscience to modify this form of treatment (e.g. by offering short-term treatment or group therapy), but the demand for help was so great that this had little impact. Also, although numerous case histories can be found of people who are convinced that psychotherapy did help them, practitioners of this form of therapy showed remarkably little interest in demonstrating that what they were offering their patients was, in fact, helpful.

As a reaction to the exclusivity of psychodynamic therapies and the slender evidence for its usefulness, in the 1950s and 1960s a set of techniques was developed, broadly termed 'behavior therapy'. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes. Second, they were loosely related to what laboratory psychologists were finding out about the mechanisms of learning, and formulated in testable terms. Indeed, practitioners of behavior therapy were committed to using techniques of proven value or, at worst, of a form which could potentially be put to the test. The area where these techniques proved of most value was in the treatment of anxiety disorders, especially specific phobias (such as fear of animals or heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts that were so obviously central to the distress that patients were experiencing. In this context, the fact that behavior therapy proved so inadequate when it came to the treatment of depression highlighted the need for major revision. In the late 1960s and early 1970s a treatment called 'cognitive therapy' was developed specifically for depression. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck, who developed a theory of depression that emphasized the importance of people's depressed

styles of thinking. He also specified a new form of therapy. It would not be an exaggeration to say that Beck's work changed the nature of psychotherapy, not only for depression, but also for a range of psychological problems.

In recent years, the cognitive techniques introduced by Beck have been merged with techniques developed earlier by behavior therapists to produce a body of theory and practice that has come to be known as 'cognitive behavior therapy'. There are two main reasons why this form of treatment has come to be so important within the field of psychotherapy. First, cognitive therapy for depression, as originally described by Beck and developed by his successors, has been subjected to the strictest scientific testing, and has been found to be a highly successful treatment for a significant proportion of cases of depression. Not only has it proved to be as effective as the best alternative treatments (except in the most severe cases, where medication is required), but some studies suggest that people treated successfully with cognitive behavior therapy are less likely to experience a later recurrence of their depression than people treated successfully with other forms of therapy (such as antidepressant medication). Second, it has become clear that specific patterns of thinking are associated with a range of psychological problems, and that treatments which deal with these styles of thinking are highly effective. So, specific cognitive behavioral treatments have been developed for anxiety disorders, such as panic disorder, generalized anxiety disorder, specific phobias and social phobia, obsessive compulsive disorder, and hypochondriasis (health anxiety), as well as for other conditions such

as compulsive gambling, alcohol and drug addiction, and eating disorders such as bulimia nervosa and binge-eating disorder. Indeed, cognitive behavioral techniques have a wide application beyond the narrow categories of psychological disorders: they have been applied effectively, for example, to help people with low self-esteem and those with marital difficulties.

At any one time, almost 10 per cent of the general population is suffering from depression, and more than 10 per cent has one or other of the anxiety disorders. Many others have a range of psychological problems and personal difficulties. It is of the greatest importance that treatments of proven effectiveness are developed. However, even when the armory of therapies is, as it were, full, there remains a very great problem – namely, that the delivery of treatment is expensive and resources are not infinite or guaranteed to be indefinitely available. Although this shortfall could be met by lots of people helping themselves, commonly the natural inclination to make oneself feel better in the present is to do precisely those things that perpetuate or even exacerbate one's problems. For example, the person with agoraphobia will stay at home to prevent the possibility of an anxiety attack; and the person with bulimia nervosa will avoid eating all potentially fattening foods. Although such strategies might resolve some immediate crisis, they leave the underlying problem intact and provide no real help in dealing with future difficulties.

So, there is a twin problem here: although effective treatments have been developed, they are not widely available; and when people try to help themselves they often make

matters worse. In recent years the community of cognitive behavior therapists has responded to this situation. What they have done is to take the principles and techniques of specific cognitive behavior therapies for particular problems and represent them in self-help manuals. These manuals specify a systematic program of treatment that the individual sufferer is advised to work through to overcome their difficulties. In this way, cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

Self-help manuals are never going to replace therapists. Many people will need individual treatment from a qualified therapist. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of cognitive behavioral self-help manuals is at an early stage, the work done to date indicates that for a very great many people such a manual will prove sufficient for them to overcome their problems without professional help.

Many people suffer silently and secretly for years. Sometimes appropriate help is not forthcoming despite their efforts to find it. Sometimes they feel too ashamed or guilty to reveal their problems to anyone. For many of these people the cognitive behavioral self-help manual will provide a lifeline to recovery and a better future.

Professor Peter Cooper
The University of Reading

PART ONE

Understanding Obsessive Compulsive Disorder

What is obsessive compulsive disorder?

A day in the life of Maureen

My day starts at 6 a.m. I am very tired as I have been obsessing during the night. I get up because if, for some reason, I am delayed by a ritual, I will start to panic that I will be late. I am filled with dread waiting for a trigger to set my mind off. After I have showered, I step out and carefully switch off the tap. I stare at the shower-head with a deep concentration to ensure it is switched off. I repeat the words 'check, check, check'. I brush my teeth at the sink. Once finished, I turn off the cold tap so hard it could snap any day. I now turn both taps in the off direction just to make sure and follow this by placing my hands under both taps to feel there is no water running: 'check, check, check'. I stare at the sink with the utmost concentration until I am convinced the water is absolutely, 100 per cent switched off. I then get a roll of kitchen towel (I go through a pack of four a day). I start by wiping over the shower door to remove any drops of water. I wipe the shower door over

and over; I know it looks perfectly clean but I do it just in case I have missed one little mark. I wipe the windowsill, the toothbrush mug (which is never used: I am too frightened of making a mess). I then clean the soap dish holder. I try to put the liquid soap bottle back on the dish so it is straight. No matter how I do it, it just doesn't look straight. Five minutes go by and I still can't do it and I start to panic. I know I am going to be late and then my whole day will be messed up. I finally get the soap into a position which, although it doesn't look quite right, is OK because I have counted to ten. By counting to ten I get comfortable with it in my mind and so can move on to the next thing. I make sure the towels are aligned and check that the floor mats are straight. I then completely clean the sink and taps so that there's not a drop of water or a single mark anywhere.

Before leaving the bathroom I repeat the checking of the shower and sink – both with my hands and with long, concentrated stares – chanting my mantra 'check, check, check', until I feel safe to move out of the door backwards, not turning away until the 'moment feels right'. I now move out of the bathroom backwards; everything is still OK. Then I switch off lights – pausing to check they are all off: 'check, check, check' – until it's safe. If there is any interruption, I have to start again.

I again resort to counting to ten as I slowly shut the door. I must not bang the door as I am sure the vibration will knock something out of place. I am not completely happy with the bathroom, but move on to the bedroom.

I then check the curtains, bed, wardrobe, and drawers to see if they are symmetrical, with everything in the right order. All my clothes are hung in groups: long-sleeved tops, dresses, jeans, skirts, T-shirts, more jeans, belts. My clothes are also colour-coordinated from the lightest shade to the darkest shade. I spend hours straightening the clothes before I feel comfortable; I actually wear the same thing nearly every day and wash it each night so I don't mess anything up. My jewellery is arranged and grouped in boxes but I don't even open the boxes any more, let alone take any jewellery out, as I am frightened of moving anything. I have to force myself to leave the room. I really want to go back in and check everything again, but it is getting late, so I don't – but I feel very anxious.

I then go into the kitchen. I avoid using the sink as it is so clean and perfect. I am frightened that if I do use it, I will never get it looking as perfect as it does now. If I have any dirty dishes, I wash them with the tap in the garden. I check the tea, coffee, and sugar jars for any marks. I always touch them using a kitchen towel as my fingers would make marks. I then check the kettle, toaster, bin, hob, oven, and coffee machine. I then wipe the cupboard doors in case there are any marks. I then check inside the cupboards, although no one touches them except me as I don't allow anyone in the kitchen. I have cans of food perfectly arranged with the labels facing outward. I avoid using any of this food. I prefer to take food out of the refrigerator, which is easier as it is all microwaveable. I gave up cooking a

long time ago as it was far too messy. I generally don't eat or drink too much anyway, as I could need to use the bathroom when I am out of the house and would not want to use any public toilets. I always travel with a roll of toilet paper just in case.

I then check the table and chairs, which have not been used for over a year. The place mats, salt and pepper pots, and flower vase are all perfectly symmetrically arranged, as are the table and chairs. I have even drawn around the chair legs just in case I knock a chair. The marks are very reassuring. It is just not worth the trouble of using the table and chairs as it would take me hours to get them all back perfectly in place. I scan the table and chairs for five minutes trying to find anything out of place. When I feel they are just right in my mind, I feel a bit less panicky.

Get ready to go out. I put things in my handbag in a precise order: 'phone, cigarettes, lighter, keys, money, credit card'. Repeat these words over and over until I feel comfortable. I call my husband to lock the door and check the stove and kitchen taps – THIS I HATE DOING. However, if I checked these, it would hold me up for another thirty minutes until I felt comfortable. I tell my husband what I have switched on, or opened, and ask him to recheck after I have left. I repeat my 'six-item handbag mantra' in front of him and then leave. Now I am at the front gate. I make sure it is closed behind me, several times. 'Check, check, check.'

At last I am in the car. Have I got my handbag? Look hard and concentrate. 'Check, check, check.' I briefly

check the six items in my bag and then drive off. At the end of the street I recheck my bag, while driving – so this check takes a while. I turn off the radio, as otherwise I can't concentrate. 'Check, check, check' until I feel comfortable. Then I recheck my six handbag items while driving – all must be spoken out loud in the right order and right rhythm until I feel comfortable.

I eventually reach the shopping centre and park the car. I then start my car-locking ritual. There are eight things to be checked in precise order and rhythm. 'Passenger window closed, my window closed, handbrake on, car in gear, lights off, ashtray closed, radio off, inside light off'. I may need to repeat this ritual several times until I feel comfortable. I must also touch all the different things as I check them. I am especially hard on the handbrake, pulling it up further each time I check it. Hence my brake cable frequently gets replaced. I can now get out of the car. I close and lock the door. Begin my five-item 'outside car' ritual. 'My door locked, my window closed, trunk locked, passenger door locked, passenger window closed.' I repeat the words 'check, check, check' at each stage until I feel comfortable. I pray that no one I know arrives in the supermarket parking lot while I am in the midst of these rituals – otherwise I have to smile, pretend to go into the supermarket, and then return when all is clear to start all over again. I flinch when I see some small girls walking across the supermarket parking lot. I get that awful thought inside my head, and anxiety and fear fill my body with dread. I freeze. 'What if I get turned on?' Horrible images bombard my head

and uncontrollable feelings fill my body. I think I must be disgusting to have such things go through my head and try really hard to push them out of my mind but I can't make them go away. Eventually I leave to make sure I don't do anything awful. I go over and over again about what having these thoughts and feelings must mean. All I can come up with is that I'm sick and disgusting. I can never be sexual, I can never be normal. I am evil and horrible . . .

Maureen has *some* of the symptoms of obsessive compulsive disorder (OCD), which is a condition characterized by the presence of either obsessions or compulsions (but commonly both). We shall define obsessions and compulsions shortly, but first want to emphasize that if you have OCD *you are not alone*. It is estimated that about 1 in 100 people has the condition to some degree. OCD can be a serious problem, and if left untreated can lead an individual to be isolated and significantly handicapped. Because of this, the World Health Organization has listed OCD *in the top ten most disabling illnesses in the world*.

Is this book for you?

Despite its many chapters, this book has a simple central message; OCD is a common problem, individuals with OCD are not crazy, and OCD *can* be overcome. The book is aimed at individuals with OCD and their families or partners. We are both clinicians and researchers with, between us, over twenty-five years' experience in helping patients with OCD.

The book will guide you through some tried and tested steps in overcoming OCD.

Our experience is that individuals with OCD may struggle with self-help books for three common reasons. If you do have any of these concerns, please do read on as there is every chance that these fears will be allayed.

The first reason is that they fear that thinking about their problem will make it worse. In fact, the opposite is true. When individuals try to avoid thinking about their OCD and what they can do about it, then the problems persist and over time become more difficult to solve. We shall try to help you develop a good psychological understanding of what is keeping your problem going and therefore of what you can do to stop OCD ruining your life.

Second, they fear that if they learn about other obsessions or compulsions, they will 'pick up' another worry. There is no evidence that you can 'catch' or exacerbate OCD from reading about other obsessions. If you develop a new obsession, then unfortunately it or a different one would probably have arisen in any case. The content of an obsession may fluctuate, but the form remains the same. This book will help you to reach a better understanding of OCD, which you can then apply to your own problems, with or without the help of a therapist.

Third, individuals with OCD believe that because obsessions can vary enormously, no one book will be able to cover all of the different types of obsessions and compulsions. Maureen has just some of the common obsessions and compulsions, but later on we will introduce several other individuals with different types of OCD. Even so, a

reader may fear that a book will not directly mention their particular obsession and for that reason will not be directly relevant to them. A related fear is that if one's own obsession is not precisely described, then the information that intrusive thoughts are safe may not apply, because 'mine is different'. This can quickly lead people to conclude that their particular obsession really *does* have a meaning, for example that it will influence the chance of bad events happening, or that it reveals something sinister about them.

OCD can have many features, and it is true that every person with OCD is unique. Every person with OCD whom we have treated has at least one feature that we have not seen before. However, there are overwhelmingly more common features than there are differences among individuals with OCD. When you read the descriptions in this book, whether of OCD itself or of treatment, try to focus on the similarities in the form rather than the differences in the content. Ultimately, one of the most helpful tools in overcoming OCD is to understand the way in which your OCD works – what is maintaining the symptoms and what the *real* problem is. If, as you work through the book, you are not sure whether certain principles apply to you, try to see if there is a way you can find out for yourself by testing that principle out.

What is an obsession?

Obsessive, but not OCD

The everyday use of the word 'obsession' often differs from what is meant by obsession in OCD. For example, the media

might describe a person who stalks a celebrity as obsessed. Someone who seems to talk non-stop about the new love in their life might be described as 'obsessed' by their friends. A person who spends most of their spare time on a hobby like plane-spotting might be described as having an 'obsession'. However, these 'obsessions' are very different from obsessions in OCD; in fact, it would be preferable, and more accurate, to use the term 'preoccupation' to describe them.

Obsessions in OCD

An obsession, in the world of OCD, is defined as a persistent thought, image, or urge that just pops into your mind and triggers distress. These obsessions are frequent, unwanted, and difficult to control or get rid of. An example of an obsession might be an intrusive thought or image about stabbing your baby. You experience this thought as very upsetting and try to push it out of your mind.

Examples of the most common obsessions are listed in Table 1.1. The percentages refer to one of the largest surveys of OCD, which was carried out by researchers in the USA. A more detailed checklist of obsessions is given in the 'Obsessive Compulsive Inventory' at the beginning of Appendix 4. Commonly, individuals with OCD have multiple obsessions, although one or two are the more dominant. (Certain 'obsessions' are excluded from OCD, including those about food – e.g. in someone with an eating disorder, who may have a number of rituals around eating – and the excessive dwelling on feelings of guilt that can occur in depression.)

Table 1.1: Common obsessions in OCD

<i>Obsession</i>	<i>Prevalence among those with OCD (%)</i>
Fear of contamination from dirt, germs, viruses (e.g. HIV), bodily fluids or excrement, chemicals, sticky substances, or dangerous materials (e.g. asbestos)	38
Doubts about harm occurring (e.g. door locks are not secure)	24
Excessive concern with exactness, order, or symmetry	10
Obsessions with the body or physical symptoms	7
Religious, sacrilegious, or blasphemous thoughts	6
Sexual thoughts or images (e.g. being a pedophile or a homosexual)	6
Urge to hoard useless or worn out possessions (although not always regarded as such by the hoarder)	5
Thoughts or images of violence or aggression (e.g. stabbing your baby)	4
Intrusive thoughts or music	1

Obsessions in OCD are not, however, simply worries about real-life problems or distressing images, but are associated in the person's mind with the power to prevent harm occurring. Almost everybody experiences some of the intrusive thoughts or urges that people with OCD have (e.g. having the urge to push someone on to a railway track, or worrying that the gas tap on the cooker might still be on). People with OCD, however, not only cannot ignore such thoughts but ascribe a different meaning to them. They believe that they have the pivotal power to cause harm or prevent bad things from happening (e.g., they believe they are dangerous when they think about pushing someone onto a railway track). Consequently, they try too hard to prevent the bad events from happening; and this in turn means that the thoughts become more frequent and distressing so that, over time, they affect all areas of the person's life.

In OCD, then, *obsessions have a special meaning, namely, that harm might occur to oneself, a loved one, or another vulnerable person through what the person with OCD might do or fail to do.* 'Harm' here is interpreted in the broadest sense and includes mental suffering – for example, some people with OCD find it difficult to articulate the meaning of their obsession; they just feel very anxious and may believe that they will go crazy, or that the anxiety will go on for ever and ever and endanger their mental or physical health. Individuals with OCD believe *they can and should prevent harm from occurring*, and this leads to trying too hard in the form of *compulsions and avoidance behaviors*. This exaggerated sense of responsibility and the consequent excessive

attempts to avoid causing harm are the very essence of OCD; we will explore this in more detail in Chapter 2.

Most people with OCD recognize their obsessions to be senseless or absurd. However, about 5 per cent of individuals with OCD are more convinced by their obsessions. They are said to hold their beliefs as 'over-valued ideas': that is, convictions that are deeply entrenched and based on values that are idealized and impossible to reach. For example, some people value perfectionism in this way; or the importance of possessions, which may be important in the development of obsessional hoarding. This small proportion of people with OCD are more difficult to help, and may require professional treatment.

What are compulsions?

Like an obsession, a compulsion also has an everyday meaning. It is defined in the dictionary as an irresistible impulse to act, regardless of the motivation. However, this includes all sorts of behaviors such as shoplifting, binge-eating, sex addiction, or gambling, which are done for immediate gratification, and are different from the compulsions of OCD.

We saw a dramatic example of the inappropriate use of the terms 'obsessive' and 'compulsive' when one of our patients brought in a newspaper article following the death of the British serial killer Dr Harold Shipman. We read the article with mounting concern. Shipman was described as being 'obsessive' over inducing death and controlling the moment of death, and as having a 'compulsive urge to kill

repeatedly'. Anyone who read the article would have concluded – as did our alarmed patient – that OCD was extremely dangerous. However, Dr Shipman was a psychopath. He was extremely callous, and enjoyed his control over others and the prospect of harming them. Such a person could not be further removed from an individual with OCD, who is a member of one of the safest groups in the world. Secure hospitals for mental disorders house hundreds of psychopaths like Dr Shipman, but have never admitted anyone with OCD. If you have intrusive thoughts about killing children, you will learn that it is extremely normal to have such thoughts, and that individuals with OCD are trying too hard to stop themselves from harming others. We would be the first to ask a person with OCD to babysit for our children and to concentrate very hard on having thoughts about killing them . . . but more about this shortly.

Another word often used to describe compulsions in OCD is 'ritual'. The two are often synonymous, although rituals usually refer to actions rather than mental acts, whereas compulsions refer to both. However, the term 'ritual' also has a popular meaning. Many people describe themselves as carrying out a 'morning ritual' to help themselves get ready for the day, but this might only mean jogging, showering, coffee, and breakfast. Religious ceremonies often involve rituals, but these are rarely as idiosyncratic as the rituals in OCD. None of these activities is part of OCD because they are not aimed at reducing anxiety and threat in the same way that compulsions are in OCD. More similar, up to a point, is the use of ritual by sportspeople, many of whom try to reduce stress by carrying

out little rituals before a big match or shot. However, the sports person is not likely to experience extreme anxiety or guilt if they resist carrying out the behavior.

Compulsions in OCD

In OCD, compulsions are acts that you repeat over and over again in response to an obsession. The aim of a compulsion is to reduce the likelihood of harm, so that you can feel 'just right' or 'comfortable', although as we shall see, over time they sometimes stop 'working'. A compulsion can be an act that may be observed by others (e.g. checking that a door is locked until you feel 'just right') or a mental act that cannot be observed by others (e.g. saying a certain phrase in your mind). Mental compulsions are often complex, and may not be repeated over and over again. An example in OCD is saying a special phrase to prevent one's partner from dying. This is referred to as 'neutralizing'. Just as with obsessions, there are many types of compulsion; some of the most common are listed in Table 1.2, which is based on the same survey as Table 1.1. Do not worry if yours is not listed in the table, as it contains only a few of the most widespread forms. (A more detailed checklist is given in the 'Obsessive Compulsive Inventory' in Appendix 4.) We never cease to be amazed that in every new patient we are asked to see there is always one symptom or variation on a theme that we have not seen before. Most people with OCD have more than one compulsion, but one or two predominate.

Certain compulsions tend to go with certain obsessions. For example, the most common combination is an obsession about contamination from germs or a bodily fluid that is

Table 1.2: Common compulsions in OCD

<i>Compulsion</i>	<i>Prevalence among those with OCD (%)</i>
Checking (e.g. gas taps)	29
Repeating acts	11
Mental rituals (e.g. special words or prayers repeated in a set manner or counting)	11
Ordering or arranging acts	6
Hoarding/collecting	3.5
Counting	2

linked with compulsive washing and cleaning. Another common combination is an obsession about causing harm leading to frequent checking (e.g. of door locks, gas taps, electrical appliances).

Compulsions like washing and checking persist because they seem to ‘work’ by reducing distress or preventing anxiety. However, over time compulsions do not always go on ‘working’. Carrying out a compulsion may briefly reduce anxiety, but in the long term it increases the frequency of the obsession and the urge to perform the compulsion again. A vicious circle is thus maintained (Figure 1.1).

One of the main differences between compulsions and the same actions performed normally by individuals without OCD is the reason for finishing a compulsion. Someone without OCD finishes washing their hands when they can

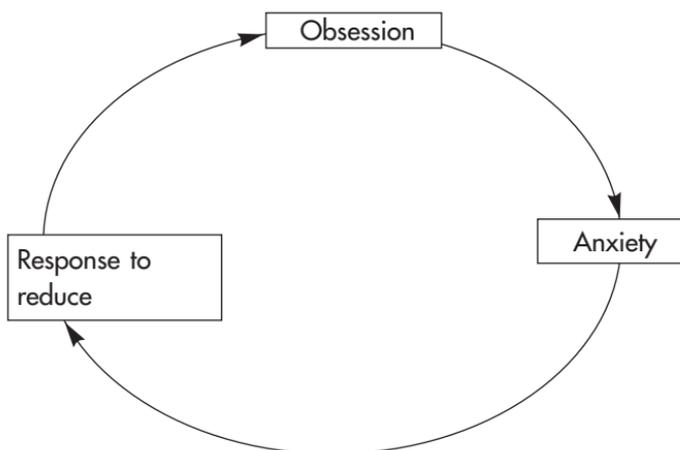


Figure 1.1 The vicious circle OCD

see that their hands are clean. However, someone with an obsessive fear of contamination finishes not when they can see that their hands are clean, but only when they feel 'comfortable' or 'just right'. This same principle can be equally applied to other compulsions. We will look at this in more detail in Chapter 2, as it is one of the main factors that maintain a compulsion and keep the person feeling dirty or unsafe. Successful therapy will involve giving up these criteria, and ending a ritual even when you feel uncomfortable or not right. Once you can do this, over time the feelings of discomfort or jarring will fade.

Not just obsessions and compulsions: avoidance behavior

Although avoidance is not part of the definition of OCD, it is an integral part of the disorder. You may be avoiding

situations to prevent yourself feeling anxious and having to carry out a compulsion. Thus, when avoidance is high, the frequency of compulsions may be low, and vice versa, like a seesaw.

An example of avoidance behavior is Christine – a woman with a fear of contamination from dirt. If she felt contaminated, she would not want to touch her body or her possessions around her home. So she would not touch toilet seats, door handles, or a wash tap used by others. She would hover over the toilet seat, open doors with her feet or elbows, use her elbow to turn on wash taps. Christine would use rubber gloves to put waste in the bin; she would avoid touching her genitals without a large amount of toilet paper; she would avoid picking items up from the floor, shaking hands with other people, or touching any substance that looked dangerous to her.

As you can see from this example, the content of obsessions, compulsions, and avoidance behavior are closely related. When Christine has to touch something that she normally avoids, then the compulsive washing starts to reduce the potential for harm and discomfort.

Another example of avoidance in OCD is Karina who has an obsessional fear of stabbing her baby. She might *avoid* being alone with her baby and put all knives or sharp objects out of sight, 'just in case' she has the urge to harm her baby. Karina tries to *avoid* thinking about it by distracting herself or suppressing the thought. When this does not work, she may perform various mental compulsions to check and confirm her memory that she has not stabbed

her baby; this, in turn, increases her anxiety and the vicious circle continues.

Another form of avoidance occurs when an individual avoids or restricts normal activities like washing or self-care because once they begin they will have to go through a lengthy compulsion. Alternatively, they may avoid or give up responsibility for checking a lock or tap because a relative has agreed to check for them.

Safety-seeking behaviors

Another term that we shall be using throughout this book is 'safety-seeking behavior'. This is defined as an action within a feared situation that is performed with the aim of preventing harm and reducing anxiety. So all types of escape from a particular situation, as well as neutralizing and performing compulsions, are forms of safety-seeking behavior. They are all ways of *responding* to an obsession.

A message we will return to over and over again is that *safety-seeking behaviors maintain obsessions*. They prevent you from testing out your fears, allow the obsession to persist, and make the problem worse in the long term. Safety-seeking behaviors are a way of 'trying too hard' to prevent bad things happening; but they don't work, because the solutions then become the problem. We will look at this pattern more closely in Chapter 2, when we go into a psychological understanding of OCD. Needless to say, if you are to overcome your OCD successfully you will need to find a way to give up all your safety-seeking behaviors. This book will help you to do this.

Pure obsessions

Some people have so called 'pure' obsessions, which are recurrent intrusive thoughts, images, or doubts without any of the compulsions shown in Table 1.2. Examples might be obsessions along the following lines: 'Why do I exist?', 'Am I studying hard enough?', 'What will happen after I die?' If this applies to you, you might be spending hours trying to resolve unanswerable questions. Although you may not be responding by performing a mental compulsion which is repeated over and over again, you probably still *respond* in ways that will be unhelpful, and which can be broadly classified as 'safety-seeking behaviors'. For example, trying to solve a problem that either does not exist or cannot be solved or analyzing a question from different angles. Inevitably this will lead to an increase in doubts and further 'But what if . . .?' type questions. What marks these out as obsessions, rather than just interesting ideas for which there are no definitive answers, is the meaning you apply to such thoughts: for example, 'I have to know the complete answer and feel comfortable before I can do anything else.'

Emotions in OCD

Some individuals with OCD find the emotional consequences of an obsession difficult to articulate. These emotions are often described in terms of 'discomfort' or 'distress'. For most people with OCD who believe that they might be responsible for preventing harm or a catastrophe in the future, the main emotion is of anxiety. This may be

severe and sudden, like a panic attack, or may be continuous worry in anticipation of harm in the future. Many also experience an emotion of disgust: either a physical disgust, for example when they think they may have been in touch with a contaminant, such as dog excrement, or a moral disgust for having intrusive thoughts. Others feel extremely ashamed and condemn themselves for having intrusive thoughts of, for example, a sexual or aggressive nature, which they believe they should not have and that others would condemn. Occasionally, a person with OCD believes that he may be responsible for a catastrophic event in the past, and feels intense guilt as a result. Many individuals are also depressed by the consequences of having OCD, for example if it occupies many hours of the day and causes other problems. Others become intensely frustrated and irritable, and OCD seriously affects their relationships with their families and friends. Thus, although in this book we concentrate mainly on the principles of overcoming anxiety and OCD, there are often other secondary symptoms such as shame, guilt, or depression that may also need attention, which we discuss in Chapter 5.

How much can OCD affect a person's life?

The severity of OCD differs markedly from one person to another, but each person's distress is very real. A person with OCD can appear to function perfectly normally despite being greatly distressed. This makes it possible for some individuals to hide their OCD – often even from their own family. OCD generally tends to have an impact on all areas

of your life – relationships, family life, social life, hobbies, and the ability to work. You can measure the degree to which OCD handicaps your life by completing the Disability Scales in Appendix 4 and then doing the same thing again during and after working through the self-help program set out in this book.

OCD often causes havoc in intimate relationships, and a large number of those with the condition are celibate. For those who do marry or enter long-term partnerships, discord, separation, and divorce are disproportionately common. There are many examples of how OCD might impact on family life. A person with OCD might try to ensure that other family members avoid touching ‘contaminated’ objects around the house, wash excessively when they have touched something ‘contaminated’, or leave certain clothes or shoes outside. Another might want other family members to check the door-lock repeatedly, or may constantly be seeking reassurance that nothing bad has happened. There are frequent difficulties taking trips or holidays. Not surprisingly, these kinds of restriction may lead to bursts of anger and growing irritation on the part of other members of the family. Sometimes individuals with OCD may be housebound, eat a very restricted diet, or be unable to prepare their food, change their clothes, or care for themselves. We look at what the caregivers and families of people with OCD can do to help in Chapter 9.

OCD tends to interfere with your ability to follow a hobby or interest or to make normal friendships. It interferes with your ability to study or work, sometimes making it impossible, and at the least putting you at a disadvantage.

Statistically, you are more likely to be unemployed if you have OCD. Lost productivity is responsible for about three-quarters of the economic cost of OCD.

It's worth repeating here that OCD is in the *top ten* most handicapping illnesses as calculated by the World Health Organization in terms of lost income and decreased quality of life. Indeed, it is worth pointing this out over and over again, almost chanting it as a mantra, to politicians, health purchasers, doctors, and psychologists until OCD is taken seriously, and more resources are made available for research, treatment, and specialist services. People with OCD do not generally tend to commit suicide or be violent, and this may be one reason why OCD is regarded as a low priority for research and clinical work; and yet someone with OCD can be just as handicapped and distressed as someone with schizophrenia or severe depression. We are certainly *not* suggesting that individuals with OCD should make attempts on their life or be violent; we are just trying to understand why so little attention, relatively speaking, is paid to OCD.

Getting treatment to overcome OCD will improve the quality of your life and give you the opportunity to improve your relationships, your social life, and your ability to study or work. We hope that reading and using this book may take you some way along that path.

How common is OCD?

OCD is more common than was once thought. In fact, it is the fourth most common mental disorder after depression,

alcohol and substance abuse, and social phobia. A team of researchers working in the late 1980s, who interviewed large numbers of people in their homes, estimated that about 2 in every 100 of the world's population have OCD at some time in their life. However, it is possible that many of these people have a mild form of the disorder that is not too disabling or that the interview technique used may have led to over-diagnosis of OCD. The true frequency of OCD in the community is therefore not known. At the core, however, are at least 1 in every 100 of the adult population who are significantly distressed and handicapped by their OCD, along with about 1 in every 200 children and adolescents.

This frequency is much the same all over the world, although the form of OCD may differ from one culture to another. This is because the content of an obsession is usually what a person does not want to think, or a kind of harm they particularly want to prevent. We are all influenced by current trends in what we see as important. For example, religious obsessions used to be very common but are now less frequent in western cultures. By contrast, contemporary concerns with health and social problems, such as AIDS and child abuse, are increasingly reflected in the obsessions described by individuals with OCD. However, while the content of obsessions and compulsions may vary across individuals, cultures, and periods, the form remains the same.

OCD is generally equally common in men and women, although there are some interesting differences in the symptoms. For example, more women than men have aggressive

obsessions and compulsions to do with washing, while men are more likely to have obsessions about numbers, symmetry, or exactness, or sexual obsessions, or to suffer from obsessional slowness. Women are especially at risk during pregnancy and in the postnatal period, probably because of the increased sense of responsibility. Young children with OCD are twice as likely to be boys as to be girls.

At what age does OCD begin?

Different individuals develop OCD at different ages. There is a group who develop OCD from the age of about six years onwards (these are more often boys than girls; we discuss these children more in Chapter 8), and there is another group that starts to develop OCD during adolescence, but the average age of onset is the early twenties. It is slightly earlier for men, who tend to develop OCD in the late teens, than for women, in whom it tends to emerge in the mid-twenties. There is, however, wide variation in the age of onset of OCD: it can occur for the first time in children as young as three and also in the elderly.

In many ways, OCD in children is much the same as in adults, although children often find it difficult to articulate the meaning of their obsession or the feared consequences of not carrying out their compulsion.

Interestingly, it is far less common to develop OCD for the first time at an advanced age. However, there are elderly individuals who have had OCD throughout their lives, but have not yet sought or received effective treatment. Some have had mild OCD for years, finding it possible to contain

within a relatively normal life, but have then experienced something significant, such as the death of a spouse or partner, which has led to their OCD becoming much worse and getting beyond their control.

One reason why the level of OCD has been underestimated in the past is that people with OCD are often too afraid or too ashamed to seek help. Often individuals with OCD struggle on by themselves for 10–15 years before they seek professional help. There is a variety of reasons for this reluctance: many individuals with OCD worry that other people will think they are crazy, do not know that their disorder is a recognized condition, or think that they should just be able to pull themselves together. We look at ways of overcoming shame at having OCD in more detail in Chapter 5.

The more OCD is acknowledged, discussed, and treated, the better it will be for all those people with the disorder, who will be able to see that many of their fears and anxieties about it are unfounded. For this reason, it is worth repeating that it is very important to raise the profile of OCD with the general public, politicians, and mental health professionals, so that OCD will not continue indefinitely to be a hidden disorder that is not taken seriously enough. Support your national OCD charities (details of which are found in Appendix 3). We all need to put OCD on the political agenda in order to improve services and raise money for research.

Can religion cause OCD?

Most religions contain ‘rituals’ – prescribed forms of speech, gesture, and action – as part of the normal rites and prayers.

OCD occurs in people from all religious backgrounds, and in those who have had no involvement in organized religion. Religion by itself does not cause OCD, but for some individuals, religion may play a role in the content of OCD. In a culture where religion is a dominant part of the usual upbringing, a religious theme may dominate the content of OCD. In other words, if you had been brought up in a different culture, you would probably have developed a different form of OCD. Research has found, too, that more severe OCD tends to be associated with more religiosity and guilt.

Examples of religious obsessions include doubts about the existence of God or religious figures, images of a sexual act with a religious figure, having to have totally 'pure' thoughts during prayer, or blasphemy. Examples of religious compulsions include repetitive praying, making the sign of a cross, or repeatedly apologizing to God. They also often overlap with other obsessions and compulsions such as contamination, checking, or repetition. Sometimes it is difficult to separate normal religious practice from OCD rituals, but the key difference is the function of the behavior.

For example, a young Jewish boy was taught to follow various commandments in his Jewish studies. Although the boy was carrying out a normal religious practice, it was done excessively (taking several hours a day) to the point where it had become disabling and dominated his life. The crucial point was that he believed – contrary to normal practice in his faith – that he was performing the ritual to prevent something bad happening to his family. The practice was excessive because the ritual had to be repeated

until he felt comfortable and was certain that he had done it perfectly and shown enough effort to demonstrate that religion was an important part of his life. In short, in his OCD the boy was distorting and exaggerating normal religious practice. He had almost developed a belief in his own God-like power to stop bad things happening to his family. In such circumstances, we usually recommend that the person temporarily drops their religious observance until they have overcome their OCD and can then choose to return to a normal religious practice.

How does superstitious behavior relate to OCD?

Superstitions are common in various cultures, often linked to magic and astrology. When taken to an extreme, they are an alternative to science or religion, attempting to provide an 'explanation' to establish chains of cause and effect and predict future events. Simple superstition is a very common feature of normal childhood thinking, when we believe that we can make things happen by making a wish, or prevent bad things from happening by a simple action. However, when superstition persists in adults it is generally driven by fear and insecurity; it reduces the feeling of uncertainty in the world and makes us feel more in control of our destiny.

Superstitious rituals in OCD are similar to 'normal' superstitions but tend to be more complex and lengthier; like other compulsions, they become disabling, and can be finished only when the person feels comfortable. A person with OCD will want to repeat the ritual if it is not done in

a precise way or at the 'right' time, or if they are not feeling completely comfortable or right. Superstitious rituals are believed to have the function of eliminating or neutralizing bad events that have come to mind. Examples include counting up to a magic number or multiples thereof, repeating specific words or images, stepping in special ways when walking, washing off bad ideas or memories, and touching certain things in a special way or a particular number of times. Superstitions can also lead to the avoidance of certain numbers (e.g. 13, 666, odd numbers), colours, ideas, or words (e.g. the devil) which are associated with bad events.

How is hoarding part of OCD?

Compulsive hoarding is a significant feature of some people with OCD, but in many ways it is different from other more common symptoms such as checking and washing. Some researchers have argued that hoarding represents a separate subtype of OCD or even a separate diagnosis. However, we follow convention in including it in our general survey of OCD. What follows here is a brief overview of what is known about hoarding and the implications for overcoming it.

Hoarding refers to the stockpiling of possessions, which can be useful or helpful in certain situations, for example where one is likely to be cut off from supplies by weather, war, or transport problems. Compulsive hoarding has been defined as the acquisition of and failure to discard a large number of possessions (or, in rare cases, animals), that

appear to be either useless or of limited value. These objects may be acquired by excessive or impulsive shopping, or by collecting free items such as newspapers or promotional giveaways, or objects that have been discarded by others. Some individuals may acquire objects by shoplifting. Hoarders develop an emotional attachment to their possessions, so that they become part of the 'self', like a limb. Where a person is suffering from compulsive hoarding, the clutter resulting from this accumulation of objects also causes significant distress or a reduced ability to function. When severe, clutter may prevent cooking, cleaning, moving freely through the house, or even sleeping. It may give rise to poor sanitation and pose a risk for fire or falls, especially in elderly people.

The definition distinguishes compulsive hoarding from the organized collection of objects that are considered interesting or valuable, where the individual collecting them can still function normally. Sometimes there is no clear boundary between compulsive hoarding and having a collection of valuable objects, but usually the distinction is fairly clear-cut.

Hoarding can also be a feature of a person with an obsessive compulsive personality (see the section later in this chapter, 'What Is an Obsessive Compulsive Personality?'). Such individuals may be extremely conscientious, meticulous, and over-attentive to detail, perfectionists, or constantly striving for control. They are often unemotional and find it difficult to be playful. They may have a rigid approach to decision-making and think in very black-and-white terms. They believe in correct solutions and want to eliminate all

mistakes and failures. They often have low self-esteem and might compensate by being overachievers. If the perfect course of action cannot be taken, they may procrastinate and avoid making a decision. For such individuals, hoarding may be a way of procrastinating, reflecting a reluctance to throw away clutter 'just in case' the items may be useful. Hoarding can also occur in the context of other psychiatric disorders such as anorexia nervosa and depression.

Hoarding, like OCD, usually starts during the early twenties and increases in severity with age. Extreme problems do not usually occur for another 10–15 years, when the individual is in their mid-thirties or older and the clutter has accumulated. Individuals who hoard tend not to marry, and to live alone. We do not know if this is because no one else can bear the same lifestyle, or if a desire for solitude is characteristic of someone who hoards.

The most important difference between hoarding and other symptoms of OCD is that it responds the least well to treatment, either by medication or through cognitive behavior therapy (CBT: the system underlying this book). As professionals, we are struck by how rare it is for individuals who hoard compulsively to seek help. The most common reason for this is that the person does not view their hoarding as a problem. Although others might see them as unable to function, the individual concerned believes that the inconvenience caused by the clutter is a reasonable sacrifice to be made and that they can adapt their lifestyle. One person's 'clutter' is another person's valued possession, and if the clutter means that it is impossible to invite a friend around for a meal or to stay the

night, then this is not viewed as a major problem. Conversely, when the clutter *is* regarded as a problem, it might be viewed as being too big a problem to tackle, and is therefore avoided until a bigger goal arises (e.g. wanting to sell one's home).

For these and other reasons, it is more often outside agencies, such as social services or an environmental health officer who is concerned about a fire hazard, that encourage compulsive hoarders to seek help. Or a partner or family member, unable to tolerate the conditions and perhaps threatening separation, may force their relative to seek help. As a result of being pressured into treatment, motivation to change is often poor, and individuals may drop out from treatment early. Even where they have sought help for themselves, they may do less well in treatment compared with other individuals with OCD receiving CBT. Hoarding does not usually respond to serotonergic medication, which is usually helpful in other individuals with OCD (see Appendix 1). However, they may do better with a dopamine blocker in addition to serotonergic drugs. You can monitor your progress in overcoming hoarding by using the Savings Inventory, which is reproduced by permission of Randy Frost, in Appendix 4. We also describe in Chapter 4, an example of someone who overcame their hoarding.

What is obsessional slowness?

A person for whom obsessional slowness is part of OCD carries out simple everyday tasks, such as washing and dressing, very meticulously and in a precise and ordered manner or sequence. As a result, it may take many hours

to get ready in the morning, and such individuals rarely reach an appointment on time! This was originally termed 'primary obsessional slowness' because it was not secondary to other compulsions, such as checking, which have taken an inordinate amount of time. Some controversy exists as to the cause of primary obsessional slowness. It could be secondary to severe compulsions of order and exactness, or there could be more biological factors involved (like a neurological disorder). Fortunately it is rare, as it is very difficult to treat. Although an individual can often 'speed up' with prompting and pacing by a therapist, the problem is helping the person to maintain any gains on their own. Expert help is often required to carry out a detailed functional analysis of the behavior and to work out a program that involves exposure to tasks done unmeticulously, imprecisely, and in a disordered manner.

Can OCD change over time?

The course of OCD can vary enormously from one person to another. The symptoms may also change, so that you may be a washer at one time and checker later in life. At one extreme, OCD can be relatively mild, consisting of one or two episodes and never returning. At the other extreme, usually when the onset is earlier, it is unremitting, constant, and more severely disabling. In between these two extremes are people for whom OCD comes and goes in episodes, usually at times of stress.

One study, carried out before effective treatments were available, found that if left untreated the majority of

individuals with OCD generally make minor improvements over the 10–20 years after onset but do continue to experience significant symptoms. About 10 per cent made no improvement and 10 per cent became worse. Fortunately, things have improved since then, and the message we want to get across is that *OCD is treatable*: it is possible either to banish it or at least diminish it so that you will get more enjoyment out of life and find it easier to function.

Extra problems with OCD

OCD often coexists with other problems, which may make it harder to treat. The most common additional problem is depression, which occurs in about one-third of individuals with OCD. Depression nearly always occurs after the onset of OCD, suggesting that it is a response to the OCD. More often, individuals with OCD do not necessarily have full-blown clinical depression but rather experience fluctuating mood, a sense of frustration and irritability with their OCD. We have included a screening questionnaire for depression in Appendix 4 (where we discuss overcoming depression in more detail). If you suffer from depression then you may find some help in Chapter 3 of this book, and also another book in this series – *Overcoming Depression* by Paul Gilbert. After years of social isolation and underachievement, individuals with OCD often have low self-esteem. If this is a problem, then we would recommend the book *Overcoming Low Self-Esteem* by Melanie Fennell (also in this series).

Another common condition that coexists with OCD is *social phobia* or *social anxiety disorder*. This consists of extreme

self-consciousness caused by a fear of being judged negatively in social situations. It usually leads to avoidance of situations, for example talking to a group, that make the person anxious. If you have social anxiety, then you may find it helpful to read the book *Overcoming Social Anxiety and Shyness* by Gillian Butler (in this series).

OCD is also often found alongside anorexia or bulimia nervosa, and alcohol or drug misuse. For eating disorders, we recommend, *Overcoming Anorexia Nervosa* by Christopher Freeman and *Overcoming Bulimia Nervosa and Binge-Eating* by Peter J. Cooper.

There are also conditions such as body dysmorphic disorder (BDD), health anxiety, morbid jealousy, trichotillomania, tics, and Tourette's syndrome that are related to OCD and regarded by some as being on the spectrum of obsessive compulsive symptoms. We will take a brief look at each of these.

Body dysmorphic disorder

BDD consists of a preoccupation with one or more aspects of one's appearance that is not noticeable to others, usually causing individuals to feel that they are ugly or very unattractive and to be very self-conscious. About 10 per cent of individuals with OCD also have BDD. Individuals with BDD usually perform time-consuming rituals such as mirror-checking and may resort to needless cosmetic and dermatological procedures. They are usually significantly depressed and their lives severely restricted. Individuals with BDD may find it helpful to read the book *The Broken Mirror* by Katherine Phillips (Oxford University Press).

We will shortly be publishing a self-help book on overcoming body image problems and body dysmorphic disorder as part of this series.

Health anxiety or hypochondriasis

This consists of a preoccupation with a fear that one has a serious disease. A large group of individuals have health anxiety that overlaps with OCD, and the two are barely distinguishable. These individuals have usually misinterpreted normal bodily sensations as evidence of impending illness and compulsively check their body and seek repeated reassurance. They have a lasting belief about being ill despite medical investigations and reassurance. The same principles we describe in this book for the purposes of overcoming OCD can also be used to overcome health anxiety; indeed, in Chapter 4 we describe an individual who had a particular fear of AIDS.

Morbid jealousy

This is characterized by a preoccupation with a fear or suspicion that one's partner is being unfaithful. It is treated like OCD as it consists of intrusive worries with compulsive checking and reassurance-seeking that the partner is remaining faithful. There is also a more severe form of morbid jealousy, associated with alcoholism or psychoses, that can lead to violence or even murder of one's partner. However, it is important to recognize that this is a quite different condition, and that in OCD intrusive thoughts of harming others are not the prelude to actual violence.

Trichotillomania

This condition often coexists with OCD. It consists of impulsive pulling at one's hair, often resulting in noticeable hair loss. Individuals experience a sense of tension immediately before pulling or when attempting to resist the urge. They then experience a sense of relief and gratification when the hair is pulled out. Trichotillomania can be helped by behavior therapy, and we would recommend the book *The Hair Pulling Problem: A Complete Guide to Trichotillomania* by Fred Penzel (Oxford University Press).

Tics

Tics are sudden, rapid, recurrent movements or vocalizations, which are involuntary, but may be suppressed temporarily. They are a common accompaniment of OCD, especially in young people. Tics have some similarities with compulsions, as seemingly driven, but purposeless, behavior. You may be able to suppress a tic for a long time or cover it up with socially acceptable behaviors – like spitting into a Kleenex or coughing following a vocal tic. Tics are classified by clinicians as being: (a) motor (movements) or vocal, and (b) simple or complex.

Simple motor tics are sudden, brief, meaningless behaviors (e.g. blinking, face grimacing, lip pouting, head jerks, tapping, nose-twitching). Complex motor tics are slower, longer, more purposeful behaviors (e.g. sustained looks, facial gestures, touching objects or self, cracking knuckles, finger-sniffing, some types of skin-picking, hair twirling, obscene gestures, biting, tapping, or jumping).

Simple vocal tics are sudden meaningless sounds (e.g. throat-clearing, coughing, sniffing, screeching, humming, barking, or grunting). Complex vocal tics are sudden sounds but are more meaningful than the simple tics (e.g. syllables, words, phrases, or statements such as 'Shut up', 'You know', 'Okay honey', 'How about it?'). Complex vocal tics can include obscene words: this is called coprolalia. Making obscene gestures is called copropraxia.

Tourette's syndrome

This is the name given to the condition of someone who has both complex motor and vocal tics, with or without coprolalia or copropraxia. Tourette's syndrome and simple tics are probably largely genetically determined. At least half of the people with Tourette's syndrome have OCD symptoms. However, OCD symptoms are more often characterized by order and counting.

Distinguishing between a tic and a compulsion can sometimes be difficult. The main differences are:

- you usually know when a tic is coming;
- you usually have a physical sensation before a tic;
- tics can generally be suppressed temporarily, but compulsions can be resisted permanently;
- tics are done without a reason, but compulsions usually have an aim of reducing anxiety or preventing harm;
- tics involve a build-up of tension which is released when you perform the action.

Tics can be helped by behavior therapy, in particular a technique called self-monitoring and habit reversal. This involves learning to perform a movement that is incompatible with the original behavior and can be tricky to do. If you need help with tics and other habits such as nail-biting and skin-picking then we would recommend the relevant chapters in *Obsessive-Compulsive Disorders* by Fred Penzel (Oxford, Oxford University Press, 2000). Tourette's syndrome can also be helped by medication that blocks dopamine receptors (for more on this, see Appendix 1).

What is an obsessive compulsive personality?

Despite the similarity in the name, obsessive compulsive personality disorder (OCPD) has only a superficial resemblance to OCD. It is sometimes referred to as anankastic personality or, after Freud, as being 'anal retentive'. It is possible for someone with OCD to have OCPD as well, although other personality traits are more common. Individuals with OCPD may be perfectionist, excessively tidy, excessively concerned with rules, and constantly making lists. They may be somewhat inflexible, unemotional, and overly devoted to work. Such traits are difficult to change, but if you do have OCD with OCPD then small shifts usually occur when you overcome OCD.

Famous people with OCD

Individuals with OCD are in good company. There are many famous people who are known or thought to have had

OCD. The lesson from this is that OCD can affect people from all walks of life. Intelligence, money, success, adoration, and fame are no protection from the problem. For obvious ethical reasons, we cannot mention here well-known individuals with OCD who are alive today! There are, however, several examples from earlier years.

Howard Hughes (1905–1976)

Howard Hughes is one of the most famous individuals known to have had OCD. He led an extraordinary life, which illustrates perfectly what happens if you have the means to capitulate completely to your OCD and insist that others accommodate it. Hughes had a fortune, and generously paid a small group of aides to follow his extensive avoidance and safety behaviors. This fatally fueled his obsessions.

At the age of eighteen, Hughes started a career in Hollywood as a producer and director after he had inherited an engineering business from his father. He also became an accomplished pilot, and set an aviation record in 1938 for the first round-the-world flight, after which he became a public figure. He was able to take enormous risks in some areas, such as test-flying new planes, and was involved in two air accidents from which he was lucky to emerge alive. One of his businesses, in the military industry (which he left others to run), was extremely successful and made his fortune. However, most of the other enterprises in which he was directly involved were abject failures, at least in part as a result of his OCD and his personality. He was too preoccupied with detail and unable to delegate or make decisions until he felt totally comfortable.

Hughes' main obsession was a fear of contamination. Early in his Hollywood career he had private investigators monitor actresses, including Ava Gardner, for signs of illness. If one of them fell ill, he insisted that she was seen by his personal physician so that he could obtain, without her knowledge, a full medical report – presumably to determine if he might have been infected.

The severity of his OCD fluctuated over the years, but, with the help of his aides, he continued to avoid contact with any 'contaminants' by minutely monitoring his environment. Eventually, he began to keep himself to a single room, seeing only his small group of aides. When he discovered that the wife of one of his aides was ill, the man was ordered to work at home and Hughes did not see him again for fifteen years.

Even while he was alive Hughes' public image was that of a reclusive eccentric; however, the true picture emerged only after his death. Hughes was especially preoccupied with the transfer of germs. He lived in a hotel room whose windows and doors were sealed with masking tape to prevent the ingress of 'germs'. The windows were also heavily draped to keep out sunlight, which he believed would encourage the proliferation of bacteria. Everything had to be handed to him covered in 'handles' of paper tissues so that it did not come into contact with germs.

On one occasion he was invited to the funeral of a business associate who had died from cancer. He could not attend, of course, because he avoided contact with everybody except his aides. However, he became convinced that the colleague had in fact died from hepatitis. He sent a

courier to the funeral with flowers and condolences, and then went to great lengths to ensure that his aides did not use that courier company again. He took steps to prevent the company from sending him any literature, or a bill, in case it had become infected following the delivery. He also gave detailed instructions on how to prevent any 'back-flow' of germs, that is, to prevent any incoming messages of thanks or mail from the grieving family or the associate's business. The belief that 'contaminants' can transfer from an infected source to another person or to an inanimate object, which can then infect you, is a common one in OCD and totally without medical foundation. What is being transferred is the *idea* of contamination.

Hughes' aides were instructed to follow numerous detailed rituals that could take hours to perform. For example, in order to remove his hearing-aid from the bathroom cabinet, his aides were instructed:

- to use six to eight tissues to open the bathroom door;
- to use six to eight new tissues to open the bathroom cabinet, remove an unused bar of soap, and clean their hands with the soap;
- to use at least 15 tissues to open the door to another cabinet containing the hearing aid; and
- to remove the sealed envelope containing the hearing aid with two hands using another 15 tissues in each hand.

Tissues were spread everywhere on the bed, chair, and bathroom floor to prevent contact with contaminants. Later he discarded his clothes and went about naked in his room in front of his aides. We presume he thought that his clothing could be contaminated and that there was less risk if he was naked. At one time, he would spend most of the day sitting naked in a leather chair in the middle of his room, in an area he called a 'germ-free zone', watching old movies. He kicked open the bathroom door to avoid touching the handle, and then banned his aides from using his bathroom.

Paradoxically, despite Hughes' fear of contamination, in later life he paid no attention to his personal hygiene. When his symptoms were severe he would urinate on the floor or against the bathroom door (presumably because he regarded opening the door or going into the bathroom as too anxiety-provoking) and refuse to allow anyone to clean it up, preferring instead for paper towels to be spread around. He did not brush his teeth and stopped cutting the nails on his hands and feet, letting them grow to a grotesque length. He did not cut his hair and rarely bathed.

Retaining his hair and nails may have been an aspect of hoarding, as he kept large vaults of memorabilia, including all the negatives and prints of his movies and thousands of feet of unused film, hundreds of scrapbooks containing photographs, newsreel, pilot logs of every minute in the air, aviation trophies, and airplane models. He spent millions storing aircraft he never visited or flew. Within his room, he was surrounded by piles of magazines, newspapers, old film cans, memoranda, and contracts. By the end of his life, he was hoarding his urine in jars.

When he was more lucid, he became preoccupied with atomic testing deep in the rocks of the Nevada desert. He tried to bribe President Johnson with \$1 million to stop the testing and gave donations of \$100,000 to Democrat and Republican presidential candidates to prevent future testing. He was not opposed to atomic weapons; he just did not want the testing done near him, probably because of his fears of contamination. In a similar vein, he besought the mayor of Nevada to improve the water-purification system as he was worried that the water had not been adequately cleansed from effluent. He drank only bottled water and ate a very restricted diet that had to be handed to him ritually to prevent contamination from 'germs'.

In effect, Hughes paid his aides and doctors to capitulate to all his avoidance and safety behaviors. He was initially prescribed codeine as a painkiller after one of the plane accidents, but became addicted to it and later injected it and increasing doses of Valium (a tranquillizer). Both drugs were probably used in an attempt to reduce anxiety, but they are addictive, and the withdrawal symptoms associated with codeine would have led to more anxiety. They are ineffective for OCD and create other problems such as constipation – although this is something he may have wanted if he thought it reduced his risk of contamination.

When Hughes died at the age of seventy-two in 1976, he was totally emaciated and an extremely sad figure. During his lifetime he had set up the Howard Hughes Medical Institute, partly as a means of reducing his tax burden. It is probable that his OCD would have influenced his expressed wish for the institute to prevent disease

whether caused by ‘bacteria, malignant growth or otherwise’. It has a current endowment of \$11 billion and now conducts research into genes and molecular biology. This is undoubtedly important work, but it would have been fitting if it could have financed some research of relevance to OCD, in view of the terrible effects the disorder had on his life. If only Howard Hughes had been born slightly later, or his OCD had been diagnosed and treated, he might have had a much happier and productive life and his inheritance might have been devoted to research into OCD!

Samuel Johnson (1709–1784)

Samuel Johnson had both OCD and Tourette’s syndrome. He was a brilliantly creative man, a greatly respected intellectual and author, and compiler of the first English dictionary. Johnson would perform highly ritualized movements when passing over the threshold of a door, as described by his biographer, James Boswell: ‘I have, upon innumerable occasions, observed him suddenly stop, and then seem to count his steps with a deep earnestness, and when he had neglected or gone wrong in this sort of magical movement, I have seen him go back again, put himself in a proper posture to begin the ceremony, and having gone through it, break from his abstraction, walk briskly on, and join his companion.’ At that time there was no understanding of OCD; such practices were simply referred to as ‘bad habit’ and ridiculed. Johnson appears also to have had obsessions involving moral standards with compulsions that probably involved prayers. He wrote in his book *Prayers and Meditations* in 1766: ‘O God, grant me repentance, grant

me reformation. Grant that I may be no longer disturbed with doubts and harassed with vain terrors,' and Boswell wrote of him: 'Talking to himself was, indeed one of his singularities ever since I knew him. I was certain that he was frequently uttering pious ejaculations; for fragments of the Lord's Prayer have been distinctly overheard.'

Charles Dickens (1812–1870)

Charles Dickens may have had OCD. He had high levels of anxiety and was universally described as 'highly strung'. Biographers have described him as being preoccupied with his hair and combing it in a mirror hundreds of times a day, which suggests a diagnosis of BDD. He had a compulsion for ordering the furniture in any room in which he stayed or worked, to try to achieve its exactly 'correct' position. Certain objects had to be touched three times for luck. Dickens compulsively tidied up after others and was angered by sloppiness. If he did have OCD or BDD, however, the disorder was probably mild, certainly not severe enough to interfere with his creativity.

Hans Christian Andersen (1805–1875)

Hans Christian Andersen was a famous Danish writer of fairy tales who it is thought had OCD and depression. According to Andersen, he 'had plagued himself to the most exquisite degree'. He would become obsessed with the idea that something he had just eaten would poison him, or that some trivial event would be exaggerated and would lead to his death. Most nights, he repeatedly

rose from his bed in order to check that he had extinguished the candle by his bed, though he had never failed to do so when he retired to bed. Andersen would often worry that he had paid the wrong amount in a shop or that he had mixed up the envelopes of the letters he had sent. He would have been unable to check this, and probably have spent many hours reviewing his actions in his mind.

John Bunyan (1628–1688)

The English author John Bunyan had OCD. In his autobiography, *Grace Abounding to the Chief of Sinners*, Bunyan vividly describes intrusive thoughts, most of which were blasphemous in nature. 'A very great storm came down upon me . . . whole floods of blasphemies, both against God, Christ, and the Scriptures, were poured upon my spirit, to my great confusion and astonishment . . . I felt as if there were nothing else but these from morning to night.' Bunyan obsessed about his urges to scream out obscenities in public and would physically restrain himself to prevent himself from acting on his impulses. 'The temper would provoke me to desire to sin . . . if it were to be committed by speaking of such a word, then in so strong a measure was this temptation upon me, that often I have been ready to clap my hand under my chin, to hold my mouth from opening.'

According to Bunyan in *Pilgrim's Progress*, 'There was a castle called Doubting Castle, the owner whereof was Giant Despair.' Bunyan's obsession that a church bell would fall on him illustrates his torturing doubt: 'I began to think,

what if one of the bells should fall? I chose to stand under a main beam . . . thinking there I might stand safely. But then I thought again, what if the bell fell with a swing, it might first hit the wall, and then rebounding upon me, might kill me, despite the beam. This made me stand in the steeple-door; and now, thought I, I am safe enough. But then it came into my head. What if the steeple itself should fall? And this thought did continually so shake my mind, that I dared not stand at the steeple-door any longer, but was forced to flee, for fear the steeple should fall upon my head.'

Martin Luther (1483–1546)

The great Reformation priest and theologian Luther was also a tortured soul who had OCD relating to religious doubts and blasphemy. In his *Commentary on Galatians* he wrote: 'When I was a monk I thought that I was utterly cast away. If at any time I felt fleshy lust, wrath, hatred, or envy against my brother, I assayed many ways to quiet my conscience, but it would not be; for the lust did always return, so that I could not rest, but was continually vexed with these thoughts: This or that sin thou last committed: thou are infected with envy; with impatience; and such other sins.' Like John Bunyan, Luther also experienced blasphemous thoughts: 'For more than a week I have been thrown back and forth in death and Hell; my whole body feels beaten, my limbs are still trembling. I almost lost Christ completely, driven about on waves and storms of despair and blasphemy against God.'

Have I got OCD?

Only a trained health professional can diagnose you as having OCD. However, there are questionnaires and checklists that may help you assess yourself.

The following is a screening questionnaire from the International Council on OCD:

1. Do you wash or clean a lot?
2. Do you check things a lot?
3. Is there any thought that keeps bothering you that you would like to get rid of but can't?
4. Do your activities take a long time to finish?
5. Are you concerned with orderliness or symmetry?

If you answered yes to one or more of these questions *and* it causes either significant distress *or* it interferes with your ability to work or study, your role as a homemaker, your social or family life, or your relationships, then there is a significant chance that you have OCD. The test is not perfect, however, and can be a bit over-sensitive at diagnosing OCD, so it may be a good idea to try another questionnaire as well.

Another good screening test is the Obsessive Compulsive Inventory devised by Professors Foa and Salkovskis (included in Appendix 4). If you score 21 or above then you are likely to be suffering from OCD. Finally, read the checklist of symptoms from the Yale Brown Obsessive Compulsive Scale (YBOCS), also reproduced in Appendix 4. If you tick any of these, then you probably have OCD. The checklist can be useful to define your most troublesome obsessions

and compulsions, and these can then be rated on the YBOCS as a measure of severity. This is widely used by professionals as a measure of severity of OCD for treatment trials to determine whether a therapy is effective or not. In summary, OCD is a complex problem with many different faces. However, as we shall describe there are some core principles of self-help that can be used to overcome this distressing problem.