ocdaction
it's time to act

Treatments for OCD

In this pack-

Cognitive Behavioural Therapy with Exposure & Response Prevention

The only proven and recommended therapy for OCD and related conditions is Cognitive Behavioural Therapy which includes Exposure and Response Prevention. This is often referred to as 'CBT with ERP'. It is considered the golden standard of OCD treatment, and is available at all levels of the NHS mental health system.

Cognitive Behavioural Therapy (CBT) is an umbrella term for a type of talking therapy that aims to understand an individual's patterns and change them through new practices. At the base of it, you and your therapist would learn how your feelings, thoughts, and behaviours affect each other and keep you stuck in unnecessary, upsetting, or harmful cycles. As the name implies, this involves a cognitive element, which looks at assumptions and how you think, and a behavioural element, which involves intentionally practicing new reactions. When treating OCD, the behavioural side of the therapy should include **Exposure and Response Prevention**, which is a particular strategy that works very directly on the OCD cycle.

Historically, the two elements have been developed separately, so there are also such things as Cognitive Therapy and Behavioural Therapy. The combination of the two is considered the best practice, as research has shown it to be more successful, and because it gives you more 'angles' to tackle the problem from. Even in their separate forms there tends to be an overlap between the two therapies, so the combination usually allows someone to get the most out of their sessions.

CBT does not focus on why you are obsessing over a particular topic or where the intrusive thoughts come from, but rather on making a change to the here and now that you are experiencing. OCD is a constant loop, so the goal is to get you out of it, and what pushed you into it in the first place isn't part of that. Like any learning process it takes time, motivation, and practice to work. CBT is a very active and hands-on therapy, with the therapist as a guide. You will be doing the majority of the work and should be given homework to do between sessions, which will integrate the learning into day to day life.

Here are a few examples of beliefs or assumptions that might maintain someone's OCD:

- I am responsible for keeping people safe
- If I don't find a solution I will worry about something forever
- I don't deserve to stop my suffering if that might harm others
- If I feel something it must be true
- There is a high risk of the worst case scenario
- If I am not perfect I am a failure, there is no in between
- The thoughts I am having mean that I am a bad person
- I should be able to control this better

Cognitive element

The goal of cognitive therapy is to make a change to the beliefs or assumptions that keep the OCD cycle going, helping you understand that you are reacting to uncertainty rather than real risk. These will be different from person to person, so at the beginning you and your therapist will work on identifying your individual experience. The therapist can offer 'psychoeducation', which means teaching you about how the brain works and what might be

going on, which can help to better understand and explain what's happening.

Depending on what the thought process is, a therapist will work through different cognitive strategies with you, which will take up part of the therapy sessions and homework. The right way to challenge current ways of thinking will change from person to person. For example, an exercise called 'Theory A/Theory B' can teach you to look at the evidence for and against a worry, without getting stuck in using it as reassurance. Another practice might be around changing the focus around the thoughts, so that instead of getting stuck on whether they're true or not, you would learn to value whether they're useful. If you have BDD or your obsessions revolve around self-worth, there might also be a focus on identifying other things that can impact positively on self-esteem. Just like there are infinite manifestations of OCD, what someone needs in therapy will vary. At the heart of it, though, cognitive work aims to reframe the context that is giving OCD so much power.

The cognitive element of CBT for OCD can also be an important part of helping you take part in the behavioural element. ERP can be very challenging, as is explained below, and takes a lot of commitment. Cognitive work can also help you work up to ERP and better prepare for it, so that you can stick to it when the time comes and make the strongest changes. Some people might find that ERP is too difficult for them to really commit to, or that the idea of it makes them too anxious. In these cases, cognitive therapy on its own can be offered, and the hope is that this helps the person both manage their OCD better and feel better able to try ERP in the future.

Behavioural element

The behavioural part of CBT focuses on the reactions, rather than beliefs, that keep the cycle going. One key aspect of this is learning about how anxiety works, how it is felt in the body, and why it causes the responses or behaviours that it does. Through this understanding and guidance from the therapist, you can then learn to respond in a new way to anxiety. This has to be a gradual process set at the right pace for you. The goal is not simply to choose a new reaction, but to build one.

Exposure and Response Prevention (ERP) works to reverse the OCD vicious cycle. The meaning that OCD attaches to intrusive thoughts causes you to feel anxious and responsible, so you use compulsions to get relief from the anxiety. This relief then reinforces the brain's assumption that the thoughts are bad, so the anxiety about them keeps getting worse. Through ERP, you practice the opposite the opposite – by choosing anxiety instead of running from it, it becomes less intense with time, and the brain re-learns how to respond to it without compulsions.

Exposure involves taking part in an action that will bring on the anxiety. **Response Prevention** means making the active choice to stay anxious instead of doing a compulsion. ERP must be done in a gradual way, because you are learning and practicing a different way of going about life and this takes time. This is called graded exposure and can be done in lots of different ways. You might start off with small things that only bring on a bearable amount of anxiety and then build up from there, or you might only hold back compulsions for a few minutes at the beginning and wait longer and longer each time. Eventually, ERP exercises will involve doing quite scary things and then waiting for the anxiety to go away by itself, without doing any compulsions.

Some people find it helpful to think of ERP as like physical exercise. Imagine your goal was to lift a 100kg weight, but you hadn't done any exercise in a long time.

It's understandable that you would need to start with small weights and then work your way up, and if you tried to lift the big weight from the start you'd probably hurt yourself. Some people feel a pressure to stop all their compulsions at once, but actually that is most likely to result in them getting overwhelmed. With graded exposure, you would start with something already manageable and work your way up.

The exercise in itself can be satisfying to complete, but if you are pushing yourself it doesn't tend to feel good in the moment. Often, you'll feel quite sore and tired the next day. Similarly, ERP is not designed to help the person feel better in the moment, but like with exercise we know it definitely does make things easier in the long run.

If you're going back to the gym for the first time in a while, the first few months are not going to feel worth it – you'll be tired, sore, bored, and you won't even feel any stronger yet! Change takes time and happens so slowly it's hard to notice. When doing ERP, a person might feel worse for a while, because they're pushing themselves to do the things they've been actively avoiding for a long time, which can be exhausting and very scary. Eventually, though, they'll be able to think back to when they started and see that they've made huge improvements.

Additional therapies

Like all mental health conditions, what someone's OCD looks like and what gets in the way of recovery will change from person to person. Some people have some extra barriers that make the therapy harder to commit to or slower to work. This might be because of the severity of your symptoms, some internal beliefs that are particularly strong because of your life experiences, or because you have other mental health conditions that make your needs more complex.

Sometimes, a CBT therapist might suggest trying a different therapy or technique based on your individual experience or barriers. If your therapist is suggesting something that isn't the recommended treatment, it should be to help you engage with CBT and ERP, <u>not</u> to replace them. Your therapist should always be able to explain

Acceptance and Commitment Therapy (ACT)

ACT is a form of CBT that focuses on helping the person accept that their intrusive thoughts happen and are not their choice, which can soften some of the impact. The goal is to help you find and build what most helps you to commit to doing the difficult things that you know will help in the long term, like ERP or stepping back from compulsions.

why they are doing something and how it will help with OCD.

These are a few examples of therapies that might be offered alongside CBT with ERP.

Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR is a trauma therapy that uses patterns and eye movements to turn traumatic memories, which feel like they are happening right now, to normal memories. It doesn't make what happened less painful, but takes away the overwhelming 'flashback' element.

EMDR is not a treatment for the OCD symptoms, but might be used before ERP in certain cases. For example, if your intrusive thoughts are tied to a traumatic event, or are so traumatic in themselves that exposure feels impossible, EMDR can take the edge off them enough to do ERP.

Compassion Focused Therapy (CfT)

CfT is a combination of CBT and other psychological treatments, which aims to support the person to develop compassion, patience, and understanding towards themselves. Shame, perfectionism, and a heightened sense of responsibility can be very big parts of the OCD cycle. You might have trouble getting into CBT with ERP because you don't feel you deserve to get better, or remain stuck on the fear that you will hurt others if you start reducing your safety-seeking behaviours. CfT explores this and aims to give you tools toward self-valuing.

Good Quality CBT for OCD

Cognitive behavioural therapy can be used to help treat or manage a huge range of things, including depression, anxiety, trauma, and pain. By nature, CBT is adapted to work with the individual problem the person is facing. Sometimes people with OCD are offered general CBT for anxiety, because the professional doesn't have the relevant training and is unaware that CBT with ERP is the recommended best practice. It is very important to make sure that the therapy you are being offered is the right type and with someone who understands it, and OCD, well enough to help. This checklist was put together to help you know what to expect.

If you have any concerns about the therapy you are having and whether it is appropriate, you should be able to speak about this with your therapist. This can be scary, because they are the professional and the expert, but a good therapist won't take it personally or get upset. In fact, they should be encouraging you to ask questions and bring up any worries. CBT doesn't look the same for everyone, so something being done differently doesn't always mean the therapist is wrong, but they should always be able and willing to explain to you why something is or is not being done as you expected. They should also be listening to you about what works, what doesn't, and why.

Session length

Sessions can change in length, but should generally be at least 45 minutes long. A 'standard' amount of time is usually 50 minutes or an hour, but occasional sessions might be longer if exposures and other exercises are being carried out. You should have a clear idea of what the plan or agenda for the session is. This is usually set at the start of the session.

Who can attend?

If there are people in your life who care for you or will be supporting you with your recovery, they might be involved in parts of your sessions. This might be a parent, partner, or someone you live with. This is so that they can get a better understanding of your OCD and how to support you. For example, you, them, and the therapist might make a plan together around reducing reassurance.

Content of sessions

The sessions should, for the most part, stay focused on your OCD, how it works, and how you are challenging it. As your recovery moves forward, your world will get bigger and some other issues might come up that you might also choose to look at. For example, if you have been very isolated because of your OCD and are starting to go out socially again, your therapist could support you with the impact of this.

You should not be spending most of the session talking about your childhood or trying to get to the 'root' of the issue. Even if there is a root, resolving it won't unstick you from the OCD cycle once you're in it. Instead, the focus should be on changing your current reactions. You might do some work around finding what deep-rooted beliefs might be making the cycle stronger, but

only in order to keep those in mind when making a plan on how to challenge the OCD.

The session should also not be mostly taken up by you talking. The therapist is there to teach, guide, and encourage you to make positive changes. Having a safe space to talk about how you're feeling or things that have happened is great and important, but that is not the main goal of CBT for OCD. Your therapist should also not be offering reassurance, arguing against your worries, or encouraging you to do so. These will only reinforce what the OCD is telling you, which is that you need to 'figure it out' in order to be free of it.

Psychoeducation

Your therapist should explain to you how your OCD works, what keeps it going, and what things can help to overcome it. The first few sessions especially will be focused on this. There are lots of ways to break this down, and usually the therapist will show you a formulation or diagram as a part of it. You should feel at all points like the therapist is able to explain what is happening or why you are doing a particular thing. Part of this might involve recommended reading, listening back to recordings of sessions, or the therapist asking you to summarise what you've learned.

Therapist-aided exposure

Your exposures should not only be done as homework. Instead, the therapist should do at least some behavioural exercises in the session with you. This allows them to teach you how to 'stick with' the anxiety, see your reactions, and encourage you. Ideally, some of these should be done in the place where your OCD most affects you, like at home. Your therapist might also perform the exposure task with you or before you to help you feel more comfortable. You should feel involved in this process, not just told to do it.

Negotiated homework

You should also have exposures to go through at home, as well as some cognitive homework. These can include practicing observing certain things to reframe your thinking or filling out forms to help you understand your own OCD. The therapist should be able to explain what the homework is and why it will help, then the two of you should discuss it and come to an agreement about what you will do. You should record your outcomes and how you felt so that you can discuss it with the therapist in your next session. Homework should not include repeating mantras, rationalising to argue back against the thoughts, or keeping a constant record of your thoughts that you can later analyse. These are most likely to give more importance to the thoughts or become compulsions in and of themselves.

Stepping back from rituals

As you become stronger against the OCD loop and get better at your exposures, your therapist should also be encouraging you to resist compulsions as part of your day to day life. While exposures are an active challenge that pushes back against the OCD, it's also important to use your increased resilience to reduce the rituals that make up your day. An early part of this might be the therapist teaching you how to recognise that you are doing them. Later in the therapy, they might encourage you to perform an exposure whenever you've performed a ritual, to cancel out the relief it brought.

This is not the same as trying to control or stop the intrusive thoughts from coming in to your mind. Your therapist should be teaching you that intrusive thoughts are completely normal and it is your fear of them, not the thoughts themselves, that are causing compulsions and anxiety.

Relationship with your therapist

Even though the therapy is quite a practical one, it does require trust and respect between you and your therapist. You should be able to trust your therapist enough to be honest with them about your symptoms and any difficulties you're having with the treatment. You should feel that your therapist cares about what you think and involves you in the process. You should also feel trusting of your therapist's ability to help, which often comes down to how well they understand

OCD and how positive they are about your ability to get better.

The relationship can be a difficult one, but because part of their job is to push you to do things that make you anxious, not because you don't feel comfortable or cared about.

Setting of goals

Your therapy should revolve around your own personal goals. The therapist should help you work out what those goals are and keep focused on them as you move forward. These should be specific and achievable, and described in terms of what you will do. They might be split into short-, medium-, and long-term goals to reflect what is most impacting you right now, what you will work on throughout therapy, and what you can keep working on in the long run after you finish with your therapist.

Tracking progress

Another part of the therapist's role is to keep track of how you're doing with the treatment. It can be hard to have an objective point of view on your own mental health and whether it's improving, especially because OCD twists things so much. The therapist should be able to remind you of how far you've come and can keep track of your progress using an OCD-specific recording method. For example, they might go through a questionnaire with you regularly in order to track how you are feeling.

Setting the pace of exposure

You should be exposing yourself throughout the therapy, and part of the therapist's job is to make sure you are doing so at the right pace. The treatment should be intense enough that you are challenging yourself and the OCD, but not so much that you get overwhelmed and can't stick with it. If you are finding it too difficult, they should reduce the intensity or work with you on the obstacles so that you are able to do it, rather than just tell you to try harder.

What to Look for in a Therapist

Whether you are going to be working with a private therapist or through the NHS, it is important that you are confident in your therapist's understanding of OCD and how to provide treatment for it. Trusting that they are guiding you in the right direction can help you take part in more challenging tasks, knowing that they will be worth it in the long term.

The two elements to look for in a therapist are knowledge about are OCD itself *and* training in how to treat it. One or the other on their own are not enough.

Unfortunately, misconceptions about OCD cause some mental health professionals to believe they do understand these when they don't. Because they haven't been trained on OCD they aren't aware that the therapy they can offer is likely to be unhelpful or even harmful.

Qualifications

If you are seeing a therapist through the NHS, then they will have the appropriate qualification for the level of treatment you are receiving. You can read about different levels of treatment in our pack about Accessing treatment through the NHS.

If you are looking for a private therapist, the search can get very confusing. Many therapists list themselves as being able to work with anyone, so searching the 'OCD' section of a directory will bring up a lot of people who don't actually have the right training. The recommended therapy for OCD is Cognitive Behavioural Therapy (CBT), but trainings in this can range from a weekend workshop to a PhD, so knowing what qualifications to look out for can be confusing.

Student or trainee therapists

You have the right to refuse to participate in teaching without your treatment being affected. This means that you can refuse to see a trainee therapist.

Trainee therapists might have less experience, but they are also more closely supervised, more up to date on current research, and often less overworked.

The simplest indicator to use is registration with a regulating body – these are organisations that set out a minimum amount of approved training for counsellors and therapists. The regulating body for CBT is the British Association for Behavioural and Cognitive Psychotherapies (BABCP). Therapists registered with the BABCP have a high level of CBT-specific qualification, supervision, and ongoing training.

To find a BABCP therapist, one option is to search their directory.

Unfortunately, not all of the therapists choose to be added to the directory, so the results might be limited. You might have better luck by using a search engine with keywords like 'OCD', 'BABCP', and, if you are looking for in-person work, the area you live in. Therapists will list which regulating bodies they are signed up with on their website, and might have the BABCP logo on there as well.

In your search for a therapist, you might come across other regulating bodies in which people list themselves as offering CBT or working with OCD. Unlike the BABCP, though, these are more general and include therapists who offer varied forms of therapy. A therapist with a mixed (or 'integrative') qualification might only have spent a short amount of time on CBT, and none at all on OCD. If a therapist is not registered with the BABCP, you might need to ask about their qualifications and training.

We suggest speaking openly with your therapist about wanting to be sure you are working with the right person and asking questions about their experience. This can be scary, because they are the professional and the expert, but a good therapist won't take it personally. In fact, they should be encouraging you to ask questions and bring up any worries. CBT doesn't look the same for everyone, so something being done differently doesn't always mean the therapist is wrong, but they should always be able and willing to explain how things work and how something applies to your OCD. They should also be listening to you about what works, what doesn't, and why.

Experts by Experience

Over the past few years, we have been contacted by more and more people with concerns or questions about unqualified therapists or 'experts by experience'. These tend to be individuals who have their own personal experience of OCD and recovery, and who use this as the basis for the support they offer.

Even though the therapy will be the same type for each individual – CBT with ERP – this still includes a huge variety of different thought exercises, diagrams, styles of exposure, and management strategies that someone can work with. The right combination of techniques for an individual is found through working with the therapist and exploring options. If someone doesn't have training in CBT, they can only show you what worked for them or go through self-help resources with you.

This does not mean that this is the case for any therapist who has personal experience of OCD, and in fact many people go on to train in psychotherapy after recovery. It is just important to remember that the personal experience cannot replace years of training and supervision.

OCD-specific knowledge

Knowledge and training around mental health have been improving for a long time, and continue to do so. This is true for obsessive-compulsive conditions and the recommended treatments for them, as well, but misinformation can still be an issue. The problem with misinformation isn't only that a professional won't have the appropriate understanding of OCD, but also that they won't know that they are missing it. This can result in misinformation being given to patients and carers and, most often, in people being offered the wrong treatment.

Your condition

Before even looking at the treatment, it's important that a therapist understands what you are struggling with. The cycles that define OCD related conditions are irrational and driven by anxiety, so an uninformed professional trying to use general strategies in what they feel is a 'common sense' way might unintentionally reinforce them.

There are also common myths and misunderstandings about different 'types' of OCD and how treatment should be adapted for these. Even a therapist who does treat OCD might feel at a loss as to how to treat a manifestation they haven't encountered before. The good news is that the treatment will remain the same no matter the themes, and CBT with ERP is always adapted to the individual, so the therapist simply needs to gain a more in-depth understanding of what your OCD looks like. This should be through speaking to you about your experience as well as doing their own research.

When you first contact a private therapist, or in your first session with an NHS one, you can ask the therapist to tell you about their experience and understanding of your condition. You might ask them to explain how it works. You can also ask them to give examples of more complex or unique cases they have heard about or worked with – this can give you a clearer picture of how in-depth their understanding might be. For example, if they mention sexually intrusive thoughts and show that they understand these are unwanted, you might feel more comfortable speaking about your own worrying thoughts.

An uninformed therapist might-

Try to rationalise with someone who has OCD, feeding into rumination and reassurance seeking

Focus on a perceived cause like social media instead of working directly against the cycle of BDD

Get frustrated at someone with a BFRB about them 'not trying hard enough' when actually the techniques they are using are inappropriate

To learn more about these conditions you can read our pack on OCD and Related Conditions

Exposure and Response Prevention (ERP)

The biggest barrier to recovery that people with OCD experience when accessing therapy is lack of training, experience, and understanding of how to use ERP.

If a therapist doesn't know about ERP they won't offer it or mention it. Not only does this mean that you are less likely to recover, you might also assume that it's because therapy doesn't work or, even worse, won't work for you. This can bring feelings of hopelessness and keep someone from seeking better-quality treatment.

On the other hand, a therapist might have adequate training in ERP but not be the right person to offer it to you. The therapist's role in CBT with ERP is not just to tell you what to do, but also to teach you how to do it, set the pace, monitor your progress, and adapt the plan so that you can best engage in it.

There is no way of knowing exactly what your therapy will, or should, look like. This is something that should be worked on throughout the therapy by you and your therapist together, in response to what works and doesn't work for you. Instead, what you can check from the beginning is your therapist's 'style' of working and whether they intend to co-create and regularly review your recovery plan. You can try versions of these questions or ask the therapist to describe how they work with OCD and look out for indicators of these in what they say.

- **Will you set out an individual and graded treatment plan for me, based on getting to know my specific experience and symptoms? Will you be adapting this as we go along?**
  They should not be assigning tasks only based on what 'type' of OCD you have. Two people who share the same obsessions and compulsions might still do completely different ERP or cognitive exercises

- **Will you set both cognitive <u>and</u> exposure exercises for me, to do during therapy as well as for 'homework'?**
  Therapy that is purely cognitive or purely behavioural does exist and can be beneficial for OCD but is only recommended for people who don't feel they can take part in both. The combination of the two is known to be the most successful option.

- **If I am having trouble doing the homework tasks, will you explore with me how to make them more accessible or, if needed, what different task I can try?**
  You should feel able to tell your therapist if you haven't been able to do something, and they should never simply tell you to try harder or keep trying. The same goes for if you are finding tasks too simple and don't feel they will make a difference.

- **Will you teach me how to do the exposure and cognitive exercises you set for me?**
  The point of ERP is to become anxious and choose to stay with the anxiety instead of doing a compulsion. This is a very big ask and can be tough to even get right at first. The idea of 'sitting with the anxiety' can be confused with overthinking, which is a compulsion and would become an actively harmful exercise. Also, the anxiety that is brought up by the ERP can cause confusion as to what you are supposed to be doing and why, even though it made sense when the therapist first explained it. Your therapist should help you throughout the therapy to make sure you understand how and why to take part in the different tasks you are set.

- **Would you be able to have some sessions with me in the place where my OCD most affects me? (for example - at home, at school, in a particular place…)**
  One facet of OCD is that it can be very directly impacted by surroundings. Many people find that their symptoms are worse in a certain place in their life. This can be because that space holds a meaning for the person's intrusive thoughts – for example the area around a secondary school can be scary for someone with BDD who fears being seen or mocked by teenagers. It can also be because the person feels less able to 'hold back' – for example, many people with OCD are more motivated to hold back their compulsions in public because of embarrassment, and then get flooded by them when they get home and don't feel the need to hide them.

Making the Most of Therapy

OCD is a treatable condition, and with the right treatment a majority of people who engage with therapy get a good quality of life back. Unfortunately, the recommended therapy for OCD, while very successful, can be quite challenging to take part in. CBT with ERP works directly to challenge the OCD cycle through changing the way someone thinks about their intrusive thoughts and the way they respond to them, including choosing to engage in activities or situations that bring on anxiety. There are a few things you can do to make your experience of therapy both easier and more likely to work for you.

Ensure that you are being offered the treatment you need

The only recommended therapy for OCD is Cognitive Behavioural Therapy (CBT) with Exposure and Response Prevention (ERP). This is a specialised type of CBT, while general CBT for anxiety is unlikely to bring to an improvement of your symptoms. If you are unsure about whether you are getting the right type of CBT, you can read more about what to look for in order parts of this pack.

Request session times that you can attend

Ideally, you want to be able attend, and be on time for, as many sessions as possible. Unfortunately, difficulty leaving the house, travelling, or other commitments can make this difficult. If you see any barriers to your attendance, try to discuss these with your therapist beforehand. They may be able to offer to see you at a more convenient time.

You have a right to reasonable flexibility around timings from work and from the NHS under the Equality Act 2010

Be honest with your therapist

It's important to communicate the contents of your obsessions. Avoiding this is a bit like not mentioning your physical symptoms when you go to the doctor. A big part of OCD is the shame that comes with it, so it's understandable that some people might want to keep their intrusive thoughts secret. However, this reinforces the idea that they are something to be feared, or that you are alone. Also, your therapist will be most able to help you if they know exactly what you're experiencing and what you're fighting against. If you don't feel you can be honest with your therapist, you can explore this with them or speak to the mental health team about working with someone who better understands your condition.

Do your homework

As with attendance, the more time you put into tackling OCD, the more you will get out of it. It's important to take part in any exposure or cognitive exercises that are set, that way the progress made within sessions can be applied to the rest of your life and will sink in better over time.

If you are having trouble with the homework, or you have concerns around whether you will be able to take part in it, speak to your therapist. It is part of their job to adapt it so that it's both challenging and doable. Your therapist should never tell you that you just need to try harder.

We run many groups over the phone or online:
OCD Action groups

We also work with independent groups throughout the country:
Local face-to-face groups

Learn more about Next Steps

Consider joining a support group

Some people find it helpful to attend support groups. This can be a way of keeping your motivation up between sessions and an opportunity to connect with other people who are in a similar position.

Consider using our Next Steps service

The OCD Action Helpline offers a support service aimed at helping people make the most of their therapy and engage in good quality CBT with ERP. This service provides 5 calls at different key points of the therapy, in which a volunteer will provide information about what to expect, check in with you about whether this is happening, and support you to work through any blocks you come across.

Consider medication

Medication is always a personal choice, and you can read more about in other parts of this pack.

A common misconception about medication is that it will make the therapy less effective. Understandably, someone might think that medication, by reducing the symptoms of OCD, will take away some of the elements they should be working with in therapy. The worry here is that, even after successful therapy, coming off medication will cause the symptoms to return because they were never actually faced. You could liken this to using crutches, because the hurt leg won't be getting any exercise while walking around.

A more accurate way of thinking about medication, on the other hand, is like a floatation device being used in a swimming lesson. If someone can't swim, using a board to hold on to while they practice allows them to focus on getting their technique right without having to worry about keeping afloat. In the long run, this means they will have learned how to swim better and quicker. Similarly, medication reduces the impact or 'stickiness' of the OCD cycle, making it easier to practice new reactions. For most people, it allows them to throw themselves into the work in a safer and more effective way.

Medication for OCD

Many people find medication to be a very helpful part of OCD recovery. It can be taken on its own or used alongside the recommended therapy. Different types of medication have been researched in relation to treating OCD or related conditions, and a few of these have been found to reliably reduce the symptoms for most people who try them.

Anti-Obsessional Medication

The recommended medication to start with is a group of tablets called Selective Serotonin Reuptake Inhibitors (SSRIs). These allow the brain to make better use of its serotonin, which is a chemical involved in lots of different processes. They can also help to a lesser degree with low moods and depression, so you might hear them referred to as anti-depressants as well as anti-obsessional.

They include:

- Fluoxetine (trade name 'Prozac')
- Fluvoxamine (trade name 'Faverin')
- Sertraline (trade name 'Lustral')
- Paroxetine (trade name 'Seroxat')
- Citalopram (trade name 'Cipramil')
- Escitalopram (trade name 'Cipralex')

Positive effects
Most people describe the effect of their medication as a softening of their symptoms, or as their OCD feeling less 'sticky'. The person might still experience intrusive thoughts that worry them, but they will find it much easier to step away from obsessing over the thought or to hold back from doing a compulsion.

All 6 of these have been found to successfully treat OCD, so no one tablet is generally better than the others to try first. For BDD, Fluoxetine is on average more helpful so should be tried first, but if it doesn't work one of the others still might. These medications have also been used occasionally to treat BFRB like skin picking or hair pulling, and some people find them beneficial, especially if they also have OCD or BDD.

Negative / Side effects
As the body adjusts to the new chemical balance, some people experience upsetting or irritating side effects. These should mainly be experienced as short-lived or minor irritations, so if they feel unbearable or last more than a few weeks, a different tablet might be a better match. Side effects can be physical, like changes in appetite or sleep. They can also be mental effects such as increased anxiety, depression, or a change in intrusive thoughts.

A 7th tablet option is also available for people who can't take or have responded poorly to SSRIs:

- Clomipramine (trade name 'Anafranil')

This tablet is older than SSRIs and, on average, is more likely to bring on side effects. Because of this, the recommendation is that someone try at least one SSRI before trying Clomipramine.

Every person will react differently to each of these tablets, so it might take more than one attempt to find the right fit. The first tablet someone tries might not have enough positive effects or could cause distressing side effects.

> Medication options for BFRB like skin picking and hair pulling are more complex and can depend on what other condition the person is experiencing, if any. The TLC Foundation for BFRB have published Expert Consensus Treatment Guidelines that go through this in more detail.

SSRI timeline

For the first few weeks, your brain and body will be adjusting to the new balance of chemicals, so you might experience worse side effects to start with

A few weeks in, some anti-depressant effects may kick in. Whether you are experiencing depression or not, you might notice your moods improving and your anxiety feeling less sharp

Anti-obsessional effects can take up to 12 weeks to kick in, so you will need to have some patience around this. When these kick in, your obsessions should feel easier to step back from

If you find that the medication helps, you should continue to take it regularly for a year so that, alongside your symptoms improving, the effects can 'sink in' and leave you less likely to relapse.

Augmentation (for OCD and BDD)

Sometimes, a person might not respond very much to anti-obsessional medication, even at the highest dose. In these cases, sometimes adding a different tablet can help. This is called augmentation, which just means 'adding on'. The extra medication taken in this case does not help the OCD or BDD by itself, but rather boosts the effect of the main medication that the person is taking (SSRI or Clomipramine).

Augmentation should be considered if the person has tried two different anti-obsessional tablets, at maximum dose, but hasn't found them helpful. It usually takes 4 weeks to find out whether the augmentation will benefit.

Augmentation for OCD

For OCD, small doses of certain tablets called 'Dopamine blockers' have been found to boost the effect of anti-obsessional medication. By themselves, these are often used to treat psychosis, so you might also hear them called 'anti-psychotics', but they are actually used for lots of conditions including depression or gut problems, so it does not mean that your OCD has anything to do with psychosis.

Not all dopamine blockers have been found to work. The options are:

- Risperidone (trade name 'Risperidal')
- Aripiprazole (trade name 'Abilify')
  - These tend to be less effective: Quetiapine (trade name 'Seroquel') and Olanzapine (trade name 'Zyprexa')

Combining Clomipramine with Citalopram can also be explored for OCD if neither of the tablets have been successful on their own.

Augmentation for BDD

For BDD, there is an anti-anxiety tablet that can be added on if the person hasn't responded well to anti-obsessional medication on its own, and this tends to help in about a third of cases:

- Buspirone (trade name 'Buspar')

Anti-anxiety medication (anxiolytics)

Because OCD causes so much intense anxiety, professionals and patients alike might turn to anti-anxiety medication to help manage day to day life. Yet, anti-anxiety medication is not recommended for treating OCD, which can be confusing.

It can help to remember that OCD is not the intrusive thoughts you experience, nor is it the anxiety these bring. What defines OCD is how stuck on these worries you get (obsessions) and that you perform repetitive safety-seeking behaviours (compulsions). The anxiety is a result of these things. Anti-obsessional medication acts directly on the 'stickiness' of obsessions and compulsions, which reduces how much time and energy you are spending on them.

Anti-anxiety medication, on the other hand, keeps the body from getting into too heightened a state of anxiety, so will keep you more relaxed. This includes reducing physical symptoms of anxiety like heart palpitations and relaxing the muscles. What it won't do is take away the obsessions and compulsions. While anti-obsessional medication is taken every day to create a new chemical balance and maintain it, anti-anxiety medication is only taken in a moment of high anxiety or panic. Some people refer to it as 'emergency medication'.

Because anti-anxiety medication can be very addictive, it is not recommended for you to use it to try to manage or reduce your symptoms. Instead anti-obsessional medication should be used. If you've just started taking anti-obsessional medication and are struggling while waiting for it to kick in, it might be helpful to use anti-anxiety medication, carefully, just to help you through those first few weeks.

Treatments Not Recommended for OCD

Treating mental health conditions often involves finding the right treatment, or set of treatments, for an individual based on their needs. There is a huge range of psychological treatments and ways of supporting people that are available both privately and through the NHS, and sometimes different treatments are offered in order to find the right one for a patient. When it comes to OCD, though, research is much clearer about what can successfully make a difference to people's quality of life.

This document aims to provide information about treatments that might be mistakenly offered for OCD or related conditions, and why they are not recommended.

Therapies

The NICE guidelines for treatment of OCD refer to the fact that, even though we know CBT with ERP is the most successful treatment, mental health professionals might suggest a different therapy. This is most likely because of their own training, which might give them the impression that the type of therapy they work with will be appropriate for everyone. So far, research on other types of therapy hasn't shown any others to reliably help to reduce or manage the symptoms of OCD.

Exposure and Response Prevention (ERP) was developed in the 1970s and was the first strategy to be successful with treating symptoms of OCD. Further research and development also found that Cognitive Behavioural Therapy (CBT) was the most successful therapy through which to take someone through ERP strategies. Decades later, CBT with ERP is still the only recommended therapy for OCD, and the only one that has been proven to be successful.

A likely reason why these therapies don't affect the symptoms of OCD is that they have a focus on emotions and the self. While emotions are deeply affected by OCD, they are not the cause of it. Instead, OCD is the result of you becoming stuck in an obsession-anxiety-compulsion cycle. Therefore, emotional relief or understanding is unlikely to cure or treat the OCD itself. CBT with ERP works directly on the cycle it is trying to break.

Sometimes, elements or strategies from these therapies might be used **alongside** CBT with ERP to help the person better understand or work with the recommended therapy. A therapist should always explain why they are using a particular therapy or technique and how it will help with the OCD symptoms.

Psychoanalysis/Psychoanalytic therapy

Psychoanalytic therapies focus on looking for the roots of current issues in past experiences, like why someone might always play the same 'role' with certain types of people or in groups. This can be actively harmful when working with OCD, as it brings the focus onto 'figuring it out' and analysing worries and experiences. This is more likely to feed into the OCD by putting more importance on the intrusive thoughts and what they might mean. The cause or trigger of someone's OCD isn't relevant to treating it, because the focus should be on getting 'unstuck' from the current cycle.

Research on the effectiveness of this type of therapy doesn't show any reliable positive results on OCD symptoms, and indicates that the time taken for the treatment would make it not worth any successes it may bring.

General counselling or psychotherapy

When treating OCD symptoms, therapy must include methods designed around the OCD cycle, especially ERP. Otherwise, psychotherapy, including CBT, is much less likely to make a real or lasting change in your symptoms. Therapy aims to support you to build more resilience, make changes in your life, and connect with your own emotions. General therapy, though, works in a less specific way through the relationship with the therapist and self-exploration.

You might choose to attend counselling in their life for support with emotional distress or stressful periods, but this is unlikely to be helpful if you are looking for support with obsessions and compulsions specifically. This is because counselling often includes reassurance and work towards reducing anxiety, both of which would feed into the OCD cycle. People who attend general counselling for their OCD tend to feel like the therapy is helping, but it is most likely that they are using it for relief rather than to challenge and reduce the OCD cycle.

Eye Movement Desensitisation and Reprocessing

EMDR is a therapy used to treat the symptoms brought on by traumatic experiences, such as PTSD (Post Traumatic Stress Disorder) or flashbacks.

These symptoms are brought on by the memory of the events not being recorded into the brain correctly, so that the brain and body react to it as if it's still happening, even years later. This therapy works by helping the brain to process the experience and learn to recall it from more of a distance. It can still be painful and scary, but it will feel like it happened in the past rather than the present.

Some local therapy services have recently been referring people with OCD to EMDR, but this is due to a misunderstanding of how it can help. EMDR doesn't in itself reduce the OCD cycle of obsessions and compulsions, but it can be a part of making CBT with ERP more successful.

Some people experience traumatic intrusive images, thoughts, or memories as part of their OCD. OCD can also develop in response to a traumatic event. Sometimes this can cause ERP to be more difficult to engage with, because of the emotional impact of it. In these cases, EMDR or similar trauma treatments can be a very successful tool that would allow you to take part in CBT with ERP.

Hypnotherapy

Hypnotherapy makes use of altering the client's state of mind through hypnosis, in theory giving them better access to parts of their self or mind. It is considered a 'complementary' therapy rather than a psychological one, because there is no strong research-based evidence to suggest that it helps with mental health conditions. Some people have found it helpful with emotional problems or breaking habits.

Because it is used in helping to break habits, some people use it or suggest it for people with OCD. There is no evidence so far that hypnosis can reduce the symptoms of OCD or support you to recover from them, but there is a chance that the habit-breaking element can help to manage them a little more easily.

Dialectical Behavioural Therapy

DBT is a very specialised style of CBT that is used to work with people who have difficulty with managing intense emotions and their responses to them. This therapy is based on intense levels of reliability and challenges to the person attending it.

People who struggle with OCD or related conditions, especially BDD, can find that managing their emotional reactions becomes more and more difficult because of the constant and distressing nature of their condition. If this happens, the focus should remain on treating the OCD symptoms, as emotional regulation will improve with this. Unfortunately, sometimes DBT or a similar treatment will be offered, incorrectly, by a mental health professional who is focusing on the external elements (not managing emotions) rather than the internal ones (obsessions, compulsions, and all the challenges they bring).

Cognitive Analytical Therapy

CAT is a combination of CBT and Psychoanalytic work, which looks at how past experiences affect current ones within the context of looking at the connections between thoughts, behaviour, and feelings.

It can be useful for self-exploration and making life changes. Like with psychoanalysis, one issue is that looking at the past doesn't help treat OCD. The other issue is that, being based on generalised CBT, the lack of exposure within this treatment also means the symptoms of OCD aren't being treated directly.

Mindfulness

Mindfulness is a technique that uses focusing on the 'here and now' and being very aware of what's happening in your mind, body, and emotions. It can be used to manage symptoms of mild anxiety or depression. Being more aware and focused on these things can help someone react differently to thoughts or feelings. It also includes concepts around patience and self-kindness.

Part of what keeps the OCD cycle going is how 'sticky' and worrying intrusive thoughts can be. Obsessions happen when you are unable to let go of irrational worries. Some of the principles of mindfulness, such as noticing thoughts without engaging with them, can be helpful as part of CBT in working on stepping back from the cycle. This would be one of the tools in your toolkit, though, rather than something that by itself will reduce the symptoms.

Trying to practice mindfulness can also turn into an unhelpful or actively harmful thing as well, though. The focus on sitting with thoughts and watching them go by can be confusing, and might bring more attention to them rather than help to 'unstick'. You might feel that you have to 'do mindfulness right' and become more anxious in trying to achieve this.

Medication

Please refer to our Medication factsheet before reading this section

Decisions around medication should **always** be made with a doctor. Individual differences like physical health and other medications can significantly affect what will be safe and successful for you. All of our information is based on the NICE (National Institute for health and Care Excellence) guidelines, which make general recommendations based on evidence-based research.

The following types of medication are explicitly not recommended for treating the symptoms of OCD.

If you have tried multiple rounds of the recommended medication for OCD, including augmentation, your doctor might prescribe one of these medication 'off-label'.

If off-label prescription is being considered, a psychiatrist with specific knowledge in treating OCD should be consulted.

Other anti-depressant medication

Anti-depressant tablets that are not found in the list of recommended medications have not been shown to reliably reduce the symptoms of OCD. Non-recommended types of anti-depressant are SNRI, NASSA, TCA (except for Clomipramine), and MOAI.

Two non-recommended anti-depressants that are commonly prescribed are Venlafaxine and Mirtazapine. **Venlafaxine** is specifically named in the NICE guidelines as a medication that should **not** usually be prescribed for symptoms of OCD.

Mirtazapine is a different type of anti-depressant from the ones listed above and is not mentioned within the NICE guidelines. There isn't any official guidance on whether it is a successful treatment for OCD, so it should not be considered until after the recommended medications are. Often, doctors choose to prescribe Mirtazapine over a recommended tablet because it can help with sleep. While sleeping better can be very helpful to recovery, a reduction of the symptoms themselves will be even more so, and this is more likely to happen with a recommended tablet.

Dopamine-blocking medication (on its own)

Certain tablets (sometimes called anti-psychotics) might be prescribed to boost anti-obsessional medication in cases of severe symptoms. This is called augmentation.

Confusion over this option and over the nature of intrusive thoughts can cause doctors to mistakenly prescribe dopamine-blocking medication on its own. The NICE guidelines specifically recommend against this.

Anti-anxiety medication (on its own)

Anti-anxiety medication keeps the body from getting into too heightened a state of anxiety, so will keep you more relaxed. This includes reducing physical symptoms of anxiety like heart palpitations and relaxing the muscles. It does not, on the other hand, reduce the frequency or intensity of the obsessions and compulsions.

Anti-anxiety tablets, also called anxiolytics, are only recommended for use **carefully** during the first few weeks of taking anti-obsessional medication, to help with the initial adjustment to them.

Neurological Interventions and Surgery

There are three types of neurological intervention that have been researched or used as treatment for OCD. These are Ablative Surgery, Deep Brain Stimulation (DBS), and Transcranial Magnetic Stimulation (TMS). None of these are currently recommended by the NICE guidelines, but they are being researched further.

Ablative surgery

Ablative surgery has been around since the 1960s as a treatment for the most extreme cases of OCD. It is also known as 'lesion surgery'. It involves interrupting a brain pathway or 'circuit' by destroying a part of it. This can be done by drilling into the skull and using intense heat, or through the use of radiation.
Currently, ablative surgery is very occasionally offered through the NHS for individuals who have had multiple and recent unsuccessful rounds of treatment at the highest levels.
It has only been found to bring a small amount of improvement, so it's only considered for people who have such severe OCD that the recommended treatments can't work. In these cases, the surgery isn't the final solution, but rather can be what makes the difference between the recommended treatments working or not.

Deep Brain Stimulation

DBS is a form of neurosurgery that has been historically used to treat Parkinson's disease and is now being researched as a treatment for OCD. This surgery involves the insertion of thin wires into specific areas of the brain, which are connected to a battery pack placed in the chest wall, and which stimulate specific areas of the brain on an ongoing basis.
Currently this is not available through the NHS and we don't have any information on accessing it privately. NICE are reviewing their guidelines, and DBS is being considered as part of this.

Transcranial Magnetic Stimulation

TMS is currently used to treat migraines and depression and is being explored as a possible treatment for OCD. TMS involves placing powerful magnets to the outside of the skull in order to reduce activity in specific areas of the brain on a temporary basis. Repeating this regularly can successfully reduce mental health symptoms, though for the treatment of OCD this might need to be continued long-term for the effects to last.
Currently this is not available through the NHS and we don't have any information on accessing it privately. NICE are reviewing their guidelines, and DBS is being considered as part of this.