Guide

US English

Understanding Obsessive Compulsive Disorder (OCD)

PSYCHOLOGYTOOLS®

Introduction

Obsessions are unwanted thoughts and images that pop into your mind which you find unacceptable, or which make you feel anxious. Compulsions are things that you do in response to your obsessions, often to stop harm from occurring, or just to make you feel better. People who experience obsessions and compulsions to a level that interferes significantly with their life are said to have obsessive compulsive disorder (OCD), and it is thought that between 1 and 2 people out of every 100 experience OCD every year [1]. Fortunately, there are some effective psychological treatments for OCD including *Cognitive Behavioral Therapy (CBT)* and *Exposure and Response Prevention (ERP)*.

This guide will help you to understand:

- **What OCD is.**
- **Why OCD might not get better by itself.**
- **Treatments for OCD.**

What is OCD?

Obsessive compulsive disorder is often misunderstood. You might have heard people refer to themselves as 'being OCD' if they like things to be arranged 'just so', but in fact obsessive compulsive disorder is about suffering from 'obsessions' and 'compulsions'. These words aren't often used in everyday language, so it can be worth knowing how psychologists understand these terms.

Obsessions

Obsessions are unwanted thoughts, images, urges, or doubts that you find unacceptable, and which make you feel anxious. They are sometimes called 'intrusive' thoughts because they pop into your mind – or 'intrude' – when you are going about your life. People with OCD find that these thoughts are repeated and persistent, and often scary, unacceptable, or disgusting. Commonly experienced thoughts include:

If you have OCD you might have a lot of thoughts like these, but they will often be focused around a particular theme. Some of the most common obsessive themes are:

Compulsions

Compulsions are things that you do, or ways that you react, in response to your obsessions. Your compulsions might be actions, rituals or behaviors that other people can observe, or they might be things that you do secretly in your mind. People with OCD normally use their compulsions either to prevent some harm that they fear might occur, or to relieve a feeling of anxiety or distress. Many people with OCD realize that their compulsions are not rational but feel compelled to carry them out anyway. Examples of common compulsions include:

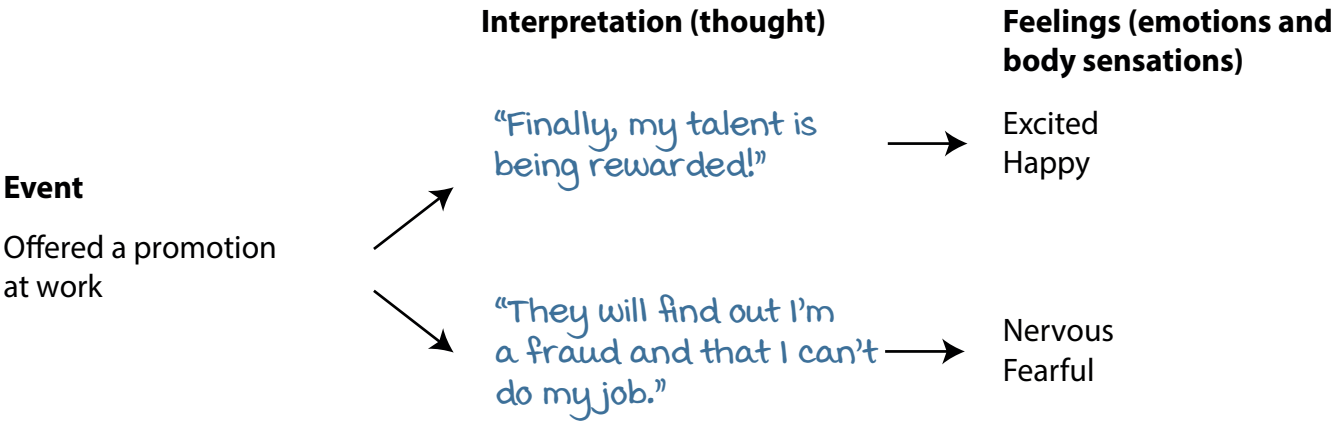
- **Repeated checking.** For example, checking that you did not harm yourself or someone else, checking that something terrible did not happen, verifying that you did not make a

mistake, checking that you turned the oven off, checking that you locked the door.

- **Washing and cleaning.** For example, washing your hands until they *feel* clean, cleaning your house or particular items obsessively, excessive washing or grooming.
- **Mental compulsions.** For example, praying to prevent harm, 'canceling' a bad thought or word with a good one, counting and ending on a 'right' or 'good' number.
- **Repeating.** For example, repeating activities, body movements, or mental events.

The link between obsessions and compulsions

Cognitive Behavioral Therapy (CBT) is a popular and effective form of psychological therapy. CBT's most important insight is that it is not the things that happen to us that make us feel good or bad, but rather the way that we *interpret* them – the meaning that we give to them – that guides how we feel. This explains why two people experiencing the same event can react to it in completely different ways. Let's look at an example:



This explains why some people are pleased when given the opportunity to sing in front of a crowd ("At last, my talent will be recognized!") when other people would be terrified at the prospect ("I will make a fool of myself and everyone will laugh at me!"). This idea can explain why some people often feel very anxious (perhaps they have a habit of interpreting situations as threatening) or very sad (perhaps they have a habit of interpreting situations very negatively).

Applied to OCD, this idea is helpful because we realize that it is not the intrusions themselves that lead to distress (because most people have intrusive thoughts without

developing OCD) [2], rather, *it is the way that people with OCD interpret their obsessions that leads to anxiety, and to responding with compulsions*. Let's consider some examples:

- John doesn't have OCD. He has the thought "what if I drove my car into those people?". He dismisses it as a stray thought, and thinks no more of it.
- Paula has OCD and has an unwanted mental image of having sex with her sister's husband. She thinks to herself "Only a terrible person would have an image like that. I must be immoral to want to have sex with him. Given the chance I would act on it". Afterwards she is on the lookout for any more unwanted images, in case they are warning sign of danger, and she avoids being near her sister's husband.
- Zain has OCD and sometimes has an urge to physically hurt someone. He thinks to himself "I could act on that thought and go to jail". Being around people is frightening, and so he often makes an excuse to leave.
- Gabriella leaves her house to go out, but half-way down the street she doubts whether she locked the door. She thinks "What if the house was broken into? It would be my fault" and so she goes back to check.
- Dairus thinks that if he wears any new clothes then something bad will happen to his daughter. He tries to keep safe and not tempt fate by never buying anything new.

We can separate the effects of OCD into how you might think, how you might feel, and how you might act:

How you might think	How you might feel	How you might act
• Intrusive and unacceptable thoughts, images, urges, or doubts which 'pop' into your mind (obsessions). • Thoughts about these obsessions and what they mean. • Thoughts about what having these obsessions says about you.	• Anxious • Afraid • Tense • Upset • Worried • Ashamed • Embarrassed • Disgusted	• Try to push the thoughts, images, urges and doubts. away. • Try to make sure that your worries don't come true. • Try to make things safe. • Neutralize unwanted thoughts with actions or rituals. • Act to reduce your feelings of responsibility. • Seek reassurance. • Avoid situations that trigger your fears.

What is it like to have OCD?

More than many other psychological conditions, the way OCD looks to an outsider can vary a great deal. These stories from Monica, Aliya, and Miguel show how OCD can affect your life.

Monica's fear that she would harm her baby

> *Shortly after my first baby was born, I started worrying that I would harm her. I would have unwanted thoughts and images of smothering or suffocating my baby, and whenever I was in a high place, I would have unwanted thoughts like "what if I threw her off?". It was horrifying – I thought this meant I was a terrible mother and couldn't be trusted to be alone with my baby. I tried to push these thoughts away as much as I could. To keep the baby safe, I insisted that my husband be responsible for most of her care. If I couldn't avoid looking after her, I would pray in my mind the whole time that nothing bad would happen. I didn't tell anyone about these thoughts in case she was taken away from me.*

Aliya's fear that she would run someone over with her car

> *I went to see a psychologist after I started a job that was a half-hour drive from my house. I got preoccupied with the worry that I would accidentally run over a pedestrian while I was driving, and it terrified me. I couldn't get this idea out of my mind, and it made driving so stressful. I was always on the lookout for pedestrians, checking my blind spot, and I wouldn't dare listen to the radio in case it distracted me. If I drove over a speed bump or pothole, I would worry that it had been a person, and I would sometimes go back to check. Even when I got to where I was going, I wouldn't be able to get the thought out of my mind. Sometimes I would get images in my mind of children lying dead in the road, and would feel sick that it had been my fault. I would doubt whether I had managed to do the drive safely, and I would replay the journey in my mind to check. When it was at its worst, I would drive back along the route to check whether there had been an accident, and I would even get out of my car and take photos to reassure myself that there hadn't been. I just wanted to be sure that nothing bad had happened, and so I would check news websites for any recent hit and run incidents. I would always call my boyfriend who was good at calming me down and reassuring me. It wasn't just driving that caused problems. I got really worried that there*

would be an electrical fire in my flat that would kill the neighbours and that it would be my fault. I would go round the flat checking all of the plug sockets and appliances before I left home. Often I would need to do it again until it felt 'right'. This would make me late for work, which made the drive feel even more stressful.

Miguel's fear that he would contract a sexually transmitted infection

My wife made me start therapy when my washing got really bad. I had become really concerned about contracting an incurable STI [sexually transmitted infection]. I was terrified of this idea that I would die and that my wife and children would be destitute without me. It got much worse after my daughter was born prematurely and I realized how lucky we were that she survived – everything in my life felt so fragile. I would notice contaminants everywhere, particularly things like blood or vomit or faeces, and had to avoid it. If I accidentally walked over anything that looked like a blood stain on the pavement, I would have to throw away the shoes I was wearing, and would definitely not take them into the house. I would try not to touch surfaces when I was out, and wore gloves whenever I could. At its worst I was washing my hands ten times in an hour, really thoroughly, until they felt clean. If I could not avoid going to the toilet, I would cover it in tissue to avoid touching it. When I got home, I would wash any clothes I had been wearing on a hot wash. The ironic thing was that I would spend so many hours cleaning at home that I barely saw my family, and I felt so anxious and guilty.

Do I have OCD?

A diagnosis of OCD should only be made by a mental health professional. However, answering the screening questions below can give you an idea of whether you might find it helpful have a professional assessment.

Do you have unwanted thoughts, images, or impulses that seem uncontrollable?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often

Do you try to get rid of these thoughts, images, or impulses?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often

Do you have rituals or repetitive behaviors that take up a lot of time in a day?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often

Do you wash or clean a lot?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often

Do you keep checking things over and over again?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often

Are you troubled by these problems?

☐ Not at all ☐ A little bit ☐ Quite a lot ☐ Very much

If you ticked the rightmost box to lots of these questions it is an indication that you could be suffering from OCD.

What causes OCD?

There is no single cause for OCD. You are more likely to experience OCD if you have:

- **Assumptions and beliefs** that make you more likely to develop OCD. Beliefs about how responsible you are, or about how important your thoughts are (particularly what having these thoughts says about you), and how 'perfect' or 'in control' you need to be are often relevant [3,4].
- **Early experiences** which made you vulnerable to OCD, or made you feel particularly responsible for preventing bad things from happening. For example, you might have had too much responsibility too early, may have experienced trauma [5], or you might have learned to be superstitious.
- **Critical incidents** such as stresses or challenges which kick-start the OCD. Situations which make you feel responsible or which give you a sense of not being in control can be very powerful triggers [6].

There may be genes which make you likely to develop emotional problems in general, but no specific genes have been found which make you likely to develop OCD [7].

What keeps OCD going?

Research studies have shown that Cognitive Behavioral Therapy (CBT) is one of the most effective psychological therapies for OCD. CBT therapists work a bit like firefighters: while the fire is burning they're not so interested in what caused it, but are more focused on what is keeping it going, and what they can do to put it out. This is because if they can work out what keeps a problem going, they can treat the problem by 'removing the fuel' and interrupting this maintainance cycle.

The important insight of CBT is that the way we feel depends on how we have interpreted what is happening to us. With OCD, this means that **the way you interpret your obsessions** will affect how you feel, and how you respond to them. Having **strong beliefs about being responsible for preventing harm** can make you more likely to interpret obsessions in problematic ways. Once you have interpreted particular thoughts as threatening, you are likely to do certain things to keep yourself or others safe [8]. These include:

- **Safety strategies,** such as avoiding certain situations which you think might be dangerous, using safety behaviors to minimize the chance of something bad happening, or seeking reassurance.
- **Neutralizing actions,** such as doing things to make unwanted thoughts or urges feel less dangerous, or to make you feel less responsible in the event that the bad thing does happen. For example, praying if you have a blasphemous thought, or washing your hands if you believe they have become contaminated.
- **Changes in what you pay attention to,** and the kinds of conclusions you draw. These 'attention and reasoning biases' might have become so habitual that they are automatic. For example, you might pay close attention to certain thoughts in case they are 'dangerous' or could lead to an unwanted outcome.

Though these actions may make you feel better in the short-term, they can actually have the unintended effect of prolonging your OCD. The diagram below describes how psychologists think OCD can get 'stuck'.

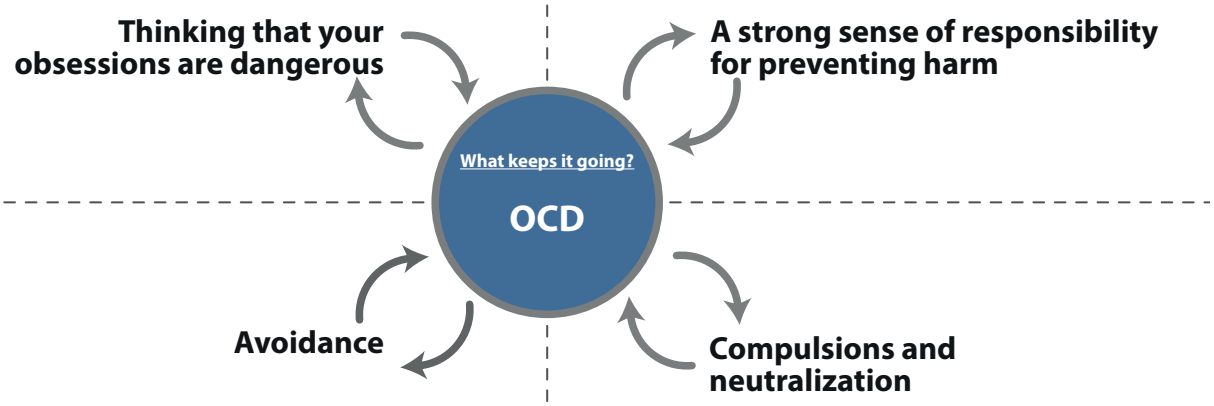
Everybody has intrusive thoughts and images that just 'pop' into their minds. People with OCD tend to interpret them as signs of danger. You might think:

- This means I am bad.
- This means I am responsible.
- Having this thought means it will happen.

If you decide that your intrusions are significant, you are likely to take action to protect yourself and others. All of the other problems of OCD flow from this decision.

We all have unspoken beliefs. People with OCD often believe that they will be responsible for causing a terrible and preventable outcome by doing something wrong, or by failing to act. You might believe that you have to take particular care about your thoughts or actions.

Having too strong a sense of responsibility can be a problem. It can 'trick' you into seeing things as more likely, more important, or more awful than they really are.



If you are worried about something then it is natural to try to avoid it. For example, if you are worried about being contaminated, you might avoid going out. If you are worried about being a danger to your children you might avoid being alone with them.

The problem of avoidance is that it 'buys into' and reinforces your belief that the intrusions are dangerous and need to be prevented or regulated. Avoidance can prevent you from learning how likely it is that your fears will come true.

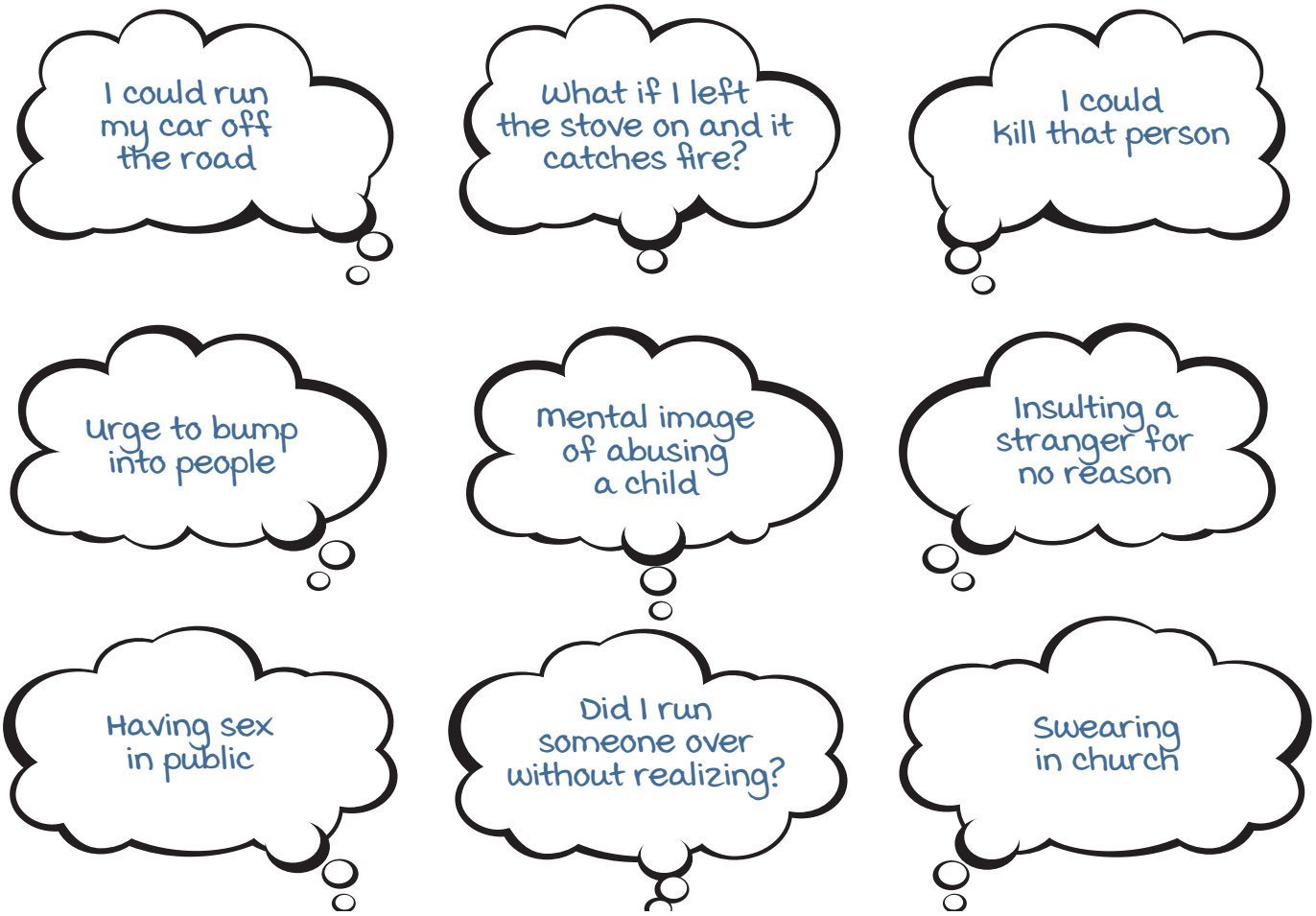
Compulsions and neutralizing behaviors are things you do in response to an obsession, particularly when you can't avoid feared situations. You might do things like washing your hands so that you don't contaminate people you love, say a prayer to cancel out blasphemous thoughts, or check the plug sockets repeatedly before you leave the house.

Compulsions and neutralizing behaviors might make you feel better in the short-term. The problem is that they reinforce your belief that the obsessions are dangerous and need to be managed or controlled.

Thinking that your obsessions are dangerous

CBT's most important insight is that it is not the things that happen to you that make you feel good or bad. Rather, it is the way that you interpret them – the meaning that you give to them – that guides how you feel. This explains why two people experiencing the same event can react to it in completely different ways.

This matters in OCD because everyone has intrusive thoughts and images – but not everyone interprets them as signs of danger. In a famous study, two psychologists asked a large group of people whether they had ever experienced particular intrusive thoughts. If you have ever had any of the thoughts below you are in good company – more than half of the people in the study said that they had experienced that thought too.



If intrusive thoughts are common, why do they only bother people with OCD? The reason is that **it is your beliefs about your thoughts that really matter**. If you think your obsessions

are dangerous, and have beliefs about being responsible for preventing harm, then you are likely to find intrusive thoughts particularly concerning.

A famous psychologist called Stanley Rachman said that people with OCD tend to give these sorts of meanings to their intrusive thoughts:

- Having these thoughts means I am a bad person.
- Thinking this makes it more likely to happen.
- Having this thought means that I am likely to lose control.
- Thinking this is as bad as doing it.

Have you ever had thoughts like these about your obsessions?

A strong sense of responsibility for preventing harm

Another reason why people with OCD tend to interpret their intrusions as being dangerous is because they have a strong sense of responsibility. In OCD this becomes focused on preventing harm. It's almost like caring too much.

We can think about responsibility as being on a spectrum. Do you know anyone who seems 'reckless', 'irresponsible', 'a risk taker', or 'careless'? Now think about yourself – which end of the line would you be on?

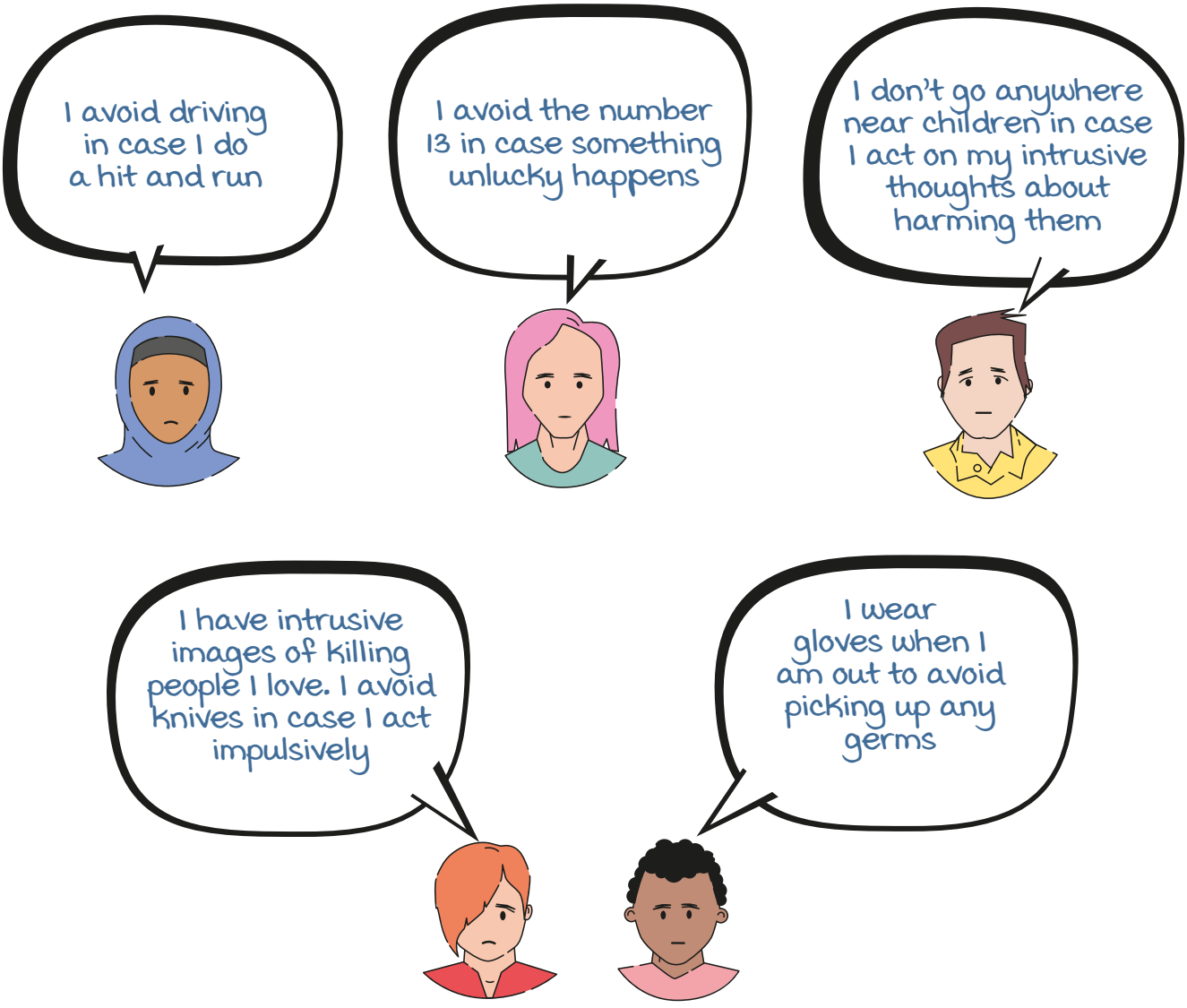
Psychologists have found that people with OCD tend to be at the 'extreme sense of responsibility' end. You might believe that you have to take particular care about your thoughts or actions, or worry that you would be responsible for causing a terrible and preventable outcome by doing something wrong, or by failing to act.

Everyone's feared outcome is different: some people worry about causing harm to themselves, others to harming people they love, or even people that they don't know. The important thing is that it would be your fault if the terrible thing were to happen.

The downside of having a very strong sense of responsibility is that it feeds your anxiety. It makes you more likely to interpret intrusive thoughts as a threat – they end up feeling very believable, demanding, and like they must be acted upon.

Avoidance

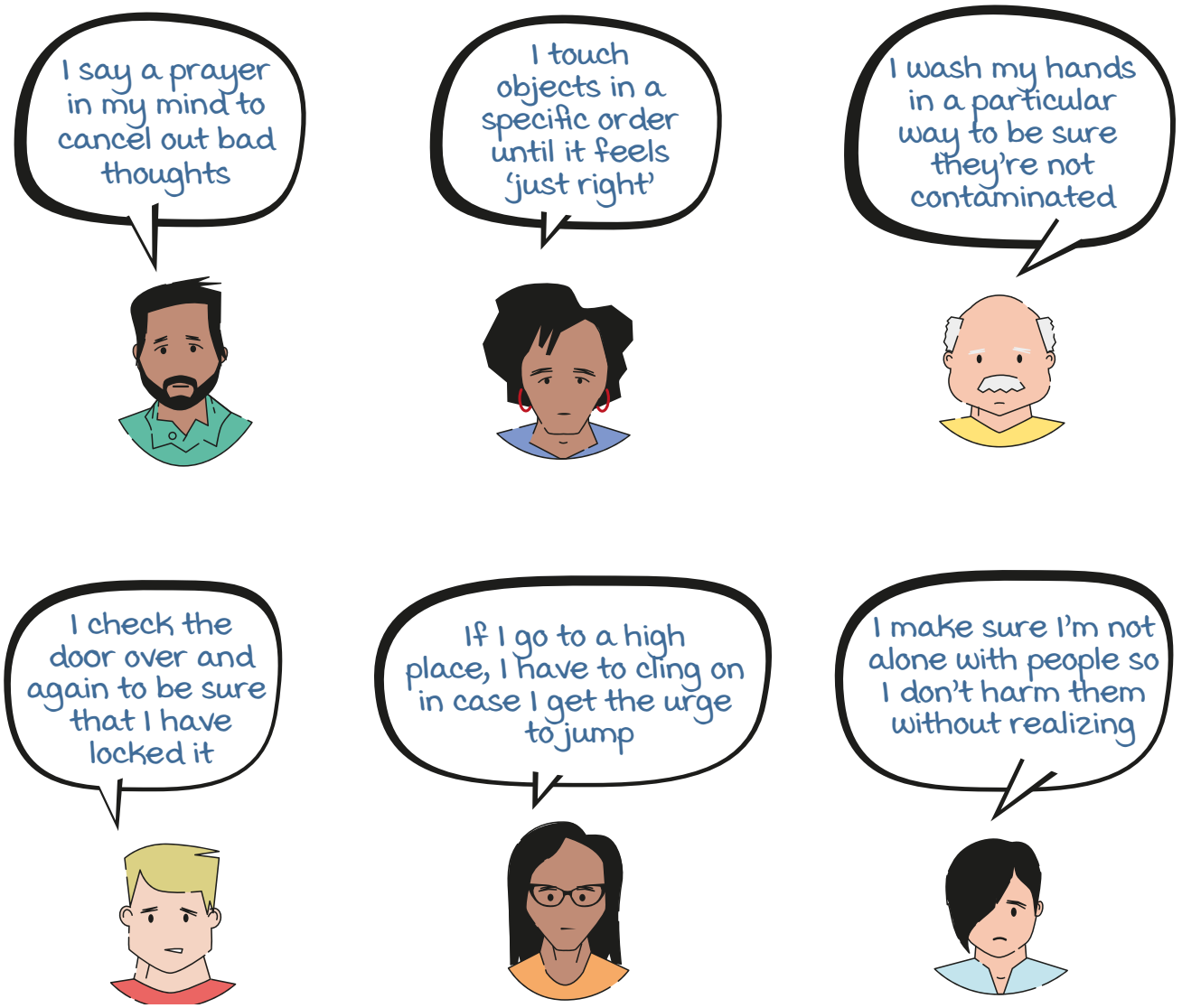
If you are worried about something bad happening, you will probably take steps to avoid it. In small amounts, avoidance can sometimes help, but this is rarely the case in OCD. People with OCD find that they end up avoiding lots of things, and that their life 'shrinks' as a result.



The problem with avoidance is that it 'buys into' the idea that your obsessions are dangerous, and that you are responsible for preventing harm. It denies you the opportunity to cope with some uncertainty and anxiety, and it prevents you from learning how safe your intrusive thoughts really are.

Compulsions and neutralization

Compulsions and neutralizing behaviors are things that people with OCD do in response to an obsession. Typically, you do these things in order to make unwanted thoughts and urges less likely to happen. Some examples of compulsions, neutralization, and safety strategies include:



To an outsider who can only see the 'end result' of the compulsion these behaviors can look a bit odd, but when we understand the interpretation that has led to the compulsion they make sense.

Trigger / Intrusion	Interpretation	Compulsion
Land on channel number 13 on a TV guide.	13 will make something bad happen.	Change channel and count to a 'safe' number.
Walking down a corridor and stepping on a dark spot of flooring.	That was blood. I'm going to get an STI.	Wash all my clothes, hands, and body until it feels right.
Intrusive image about hurting my girlfriend.	This means I could act on it. I'm dangerous.	When I'm with my girlfriend I sit on my hands.
Questioning if I'm gay.	Maybe I am.	Seek reassurance by looking at good looking men in the gym and checking whether I'm aroused.
Waiting for my train and having an urge to throw a passenger off the platform.	Having this thought means I could act on it.	Move away from the person.

The problem with compulsions and neutralization is that they reinforce your belief that your intrusions are dangerous. They keep you feeling responsible for preventing harm, and that you have to go 'above and beyond' to keep yourself and others safe.

Using your compulsions prevents you from learning:

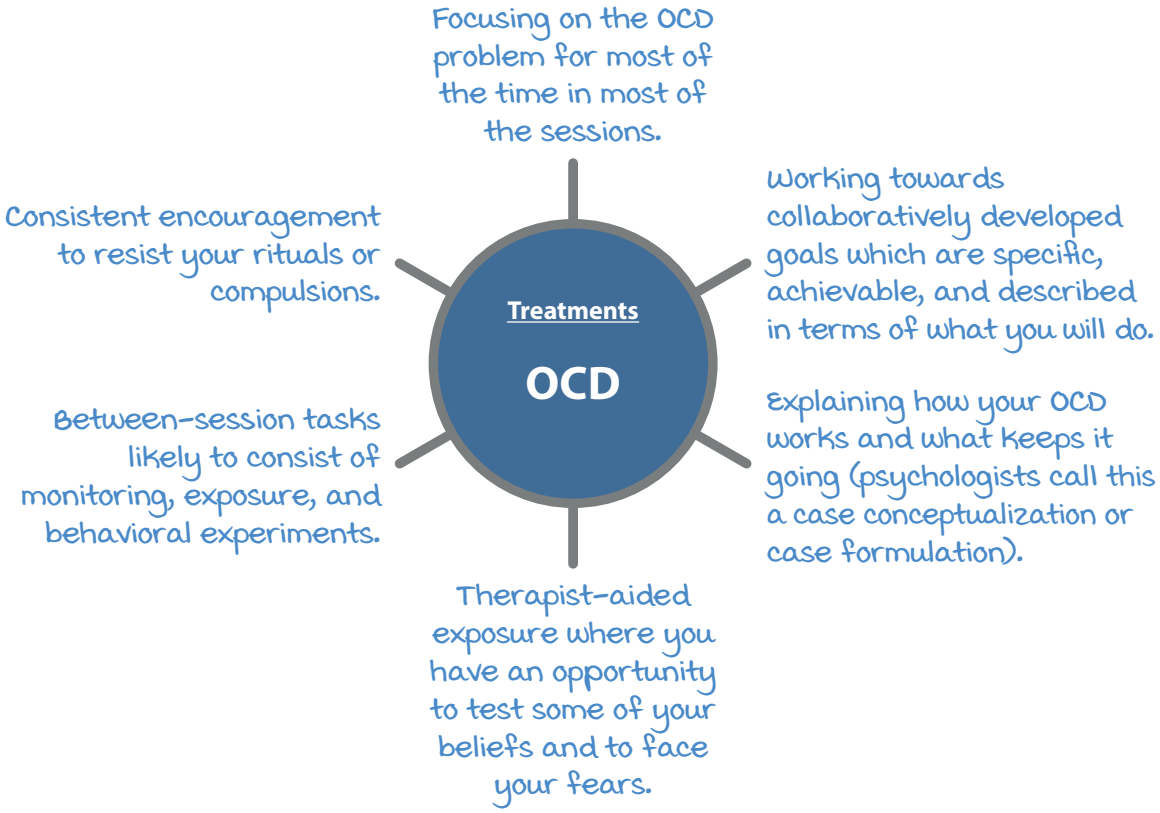
- How safe these situations really are.
- How likely it is that your fears are accurate.
- What your intrusions really mean.

Treatments for OCD

Psychological treatments for OCD

The most effective psychological treatments for OCD are cognitive behavioral therapy (CBT) and exposure and response prevention (ERP). Specialist guidelines recommend that if you have OCD where the degree of impairment is mild, you should be offered a minimum of 10 hours with a therapist, or longer if the OCD is more severe [9].

CBT is a popular form of talking therapy. CBT therapists understand that what we *think* and *do* affects the way we *feel*. Unlike some other therapies, it is often quite structured. After talking things through so that they can understand your problem, you can expect your therapist to set goals with you so that you both know what you are working towards. At the start of most sessions you will set an agenda together so that you have agreed what that session will concentrate on. OCD specialists have made some recommendations about what high quality CBT for OCD should look like [10]. The most important 'ingredients' include:



Do you remember Monica's story at the beginning of this guide? Here's how she learned to cope with her OCD:

> *I was initially reluctant to see a therapist as I thought my baby might be taken away from me. I discussed intrusive thoughts with my therapist and together we developed different theories about what might be happening to me. One theory was that "I'm a terrible mother and I can't be trusted to be alone with my child". The alternative theory was "I would never harm my baby, but my anxiety problem makes me doubt this". We looked at the evidence for these two theories, and I hoped the second was true, but didn't really believe that it was. We then drew up a list of situations that I had been avoiding and practiced exposing myself to them. Tasks like feeding or bathing my baby initially made me very anxious because I would get such frightening intrusive thoughts, but with encouragement from my therapist I kept going. I experimented with allowing my intrusive thoughts to be present rather than pushing them away. One of the most helpful things that I did was to test my belief that I was a terrible mother by asking other mothers to complete an anonymous survey about the thoughts and images that they experienced. I was relieved to find that I was far from alone. By the end of therapy, I could spend time alone with my baby without being scared of harming her. I wrote a letter to myself and part of it said "Your OCD is like an over-cautious friend – it's looking out for you but it's trying too hard. You're a good mother, and the OCD only developed because you care so much."*

A CBT technique called behavioral experiments helped Aliyah to understand her worries:

> *It was helpful when my therapist explained to me about obsessive thoughts and doubts, and the compulsions that follow them. She got me to think about myself and what I believe, and she encouraged me see my beliefs as a theory; mine was "I am a reckless and dangerous person so I have to be extra careful". We came up with an alternative that was "I'm actually a really careful person and my OCD means that I worry too much that I could have hurt someone, and my checking makes the worries worse". One of the things we did in therapy was an experiment where I had to stop checking whether I had hit someone, and had to stop calling my boyfriend for reassurance, and see what happened to the doubts that came into my mind. At first it was horrible having to sit with the doubts and the feeling that I might have hurt someone, but in the end I doubted less. My therapist also helped me to practice driving in a different way. In sessions, she*

> *would get me to practice imagining driving in the way that a 'confident and brave' version of me would drive. I still get doubts, but she helped me to see that I care about being a good person, and that's the place where these doubts come from – my job is to let go of the need to be absolutely sure.*

Miguel exposed himself to his fears, and became more able to cope with them:

> *I didn't want to start therapy, but I couldn't carry on the way things were. It was an eye-opener. My therapist asked me lots of questions and I told him about some of my fears. I had always prided myself on being a responsible person, and he helped me to see that taking my responsibilities so seriously was having enormous effects on how I was living. He would keep asking questions like "what does the OCD want you to do in that situation?" and we made a big list of all the things I was avoiding because of my worry about getting contaminated. The difficult bit of therapy was when we practiced *not* doing what the OCD wanted me to do – so I would have to touch dirty things without washing for a while. Looking back it seems odd to write about, but at the time this was such a frightening thing to do. And these practices got harder – I even had to start doing 'anti-OCD' things like sitting in the waiting room of my local hospital STI clinic without wearing my gloves. Was it helpful? Yes! I still have thoughts about getting contaminated, but they don't affect me like they used to. I can spend proper time with my family now.*

Medical treatments for OCD

The UK National Institute for Health and Care Excellence (NICE) recommends that medications called selective serotonin reuptake inhibitors (SSRIs) can be effective in treating adults with OCD [8].

References

[1] Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry,* 62(6), 617-627.

[2] Purdon, C., & Clark, D. A. (1993). Obsessive intrusive thoughts in nonclinical subjects. Part I. Content and relation with depressive, anxious and obsessional symptoms. *Behaviour Research and Therapy*, 31(8), 713-720.

[3] Obsessive Compulsive Working Group (1997). Cognitive assessment of obsessive-compulsive disorder. *Behaviour Research and Therapy*, 35(7), 667–681.

[4] Cougle, J. R., Lee, H. J., & Salkovskis, P. M. (2007). Are responsibility beliefs inflated in non-checking OCD patients? *Journal of Anxiety Disorders*, 21(1), 153-159.

[5] Lochner, C., duToit, P. L., Zungu-Dirwayi, N., Marais, A., vanKradenburg, J., Seedat, S., Niehaus D. J. H., Stein, D. J. (2002). Childhood trauma in obsessive-compulsive disorder, trichotillomania, and controls. *Depression and Anxiety*, 15, 66–68.

[6] Fontenelle, L. F., Cocchi, L., Harrison, B. J., Shavitt, R. G., do Rosário, M. C., Ferrão, Y. A., … & de Jesus Mari, J. (2012). Towards a post-traumatic subtype of obsessive–compulsive disorder. *Journal of Anxiety Disorders*, 26(2), 377-383.

[7] Mattheisen, M., Samuels, J. F., Wang, Y., Greenberg, B. D., Fyer, A. J., McCracken, J. T., … & Riddle, M. A. (2015). Genome-wide association study in obsessive-compulsive disorder: results from the OCGAS. *Molecular Psychiatry*, 20(3), 337.

[8] Salkovskis, P. M., Forrester, E., & Richards, C. (1998). Cognitive–behavioural approach to understanding obsessional thinking. *The British Journal of Psychiatry*, 173(S35), 53-63.

[9] National Institute for Health and Care Excellence (2005). *Obsessive compulsive disorder and body dysmorphic disorder: treatment*. Retrieved from: https://www.nice.org.uk/guidance/cg31/resources/obsessivecompulsive-disorder-and-body-dysmorphic-disorder-treatment-pdf-975381519301

[10] Darnley, S., Forrester, E., Heyman, I., Stobie, B., Salkovskis, P, Veale, D. (2019). *CBT Checklist for OCD*. Retrieved from: https://www.ocdaction.org.uk/support-info/have-i-had-cbt-my-ocd

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