

Have I had CBT for my OCD?

The National Institute for Health and Clinical Excellence (NICE) is the organisation responsible for setting guidelines for the NHS on how to treat Obsessive Compulsive Disorder (OCD). According to these guidelines, if you have been diagnosed with OCD, you should be offered Cognitive Behavioural Therapy (CBT).

People with OCD sometimes contact OCD Action to say that they are receiving some therapy but are not sure if this is CBT. Some people also contact the Charity to say that they are not sure if the CBT they are receiving is of the quality that it needs to be to help them.

If you have any doubts about the therapy that you are receiving, you can use this checklist to compare your own treatment with what has been demonstrated to be the most effective out-patient CBT therapy.

1. How long should sessions last?

Sessions should last at least 45 minutes on average with an agenda that is agreed at the start of each session. Some sessions may be longer especially if confronting feared situations or objects.

2. Who else can attend the session?

Depending on your age and circumstances, with your agreement some sessions might involve your parents or other family members. Sometimes sessions may involve a spouse or other household member. This can be essential to help family members understand the nature of OCD for example how they can best help you by not accommodating your rituals and giving you reassurance.

3. Content of sessions

The content should stay very focused on the OCD problem for most of the time in most of the sessions (and not mainly other problems, although sometimes other issues may be dealt with later in therapy).

4. Setting of goals

The therapist should help you develop and work towards an agreed set of goals for and after treatment. These should be specific and achievable and described in terms of what you will do (e.g. to hold my baby; to sit on a public toilet seat).

5. An explanation of how your OCD works

You should be provided with a clear rationale and explanation of how your OCD works, what keeps it going and therefore what you need to do to overcome it. This is usually called “a formulation” and might consist of a diagram.

Different therapist may place a different emphasis on either the “cognitive” or the “behavioural” aspects of OCD. A more “cognitive” explanation may focus on the meaning that you attach to your obsessions (for example “Because I have thoughts about being a paedophile it must mean that I could act upon them and I am bad for having them” or “When I feel contaminated and do not wash, then I think I might lose control and it will go on for ever”).

This approach allows you and your therapist to look for an alternative understanding of the intrusive thoughts and feelings (for example that “it is very important for you to care for children and are very worried about harming children” and a different way of behaving that is consistent with your values). You might also understand how the criteria you use to finish a ritual, such as feeling “right”, “comfortable” are a problem and keep the OCD going.

A more “behavioural” explanation might emphasise education about anxiety, how anxiety is experienced in the body, how facing up to your fears may initially increase but then become easier each time you repeat the task.

Whatever the emphasis, the important thing is you have a good understanding of what keeps your OCD going and what you will need to do overcome it.

6. Therapist aided exposure

The therapist should do at least some exposure or behavioural experiments with you in the sessions to test out your predictions and allow yourself to experience anxiety. Ideally this should occur at least once in your home or where the OCD is worst. Alternatively the therapist might demonstrate the exposure task first in front of you (e.g. touching a toilet seat in front of your first). You should feel involved in this process, and not just be told to do it. Exposure and behavioural experiments should be negotiated and you should understand why there is a need to do them.

7. Negotiated homework

The therapist should negotiate relevant homework tasks to do between the sessions. This is also likely to consist of exposure tasks or behavioural experiments to test out your predictions and should be relevant towards achieving your goals. The outcome of these tasks should be recorded and reviewed when you next meet. Alternatively homework might consist of keeping a record of the frequency of your checking.

8. Encouraged to do exposure

You should be consistently encouraged or requested to perform activities that involve exposing yourself to activities, situations or thoughts that you avoid. Difficulties should be discussed and an agreed plan of action is made co-operatively.

9. Encouraged to resist your rituals

You should be consistently encouraged and supported to resist rituals (for example the urge to seek reassurance or to “check” or “put things right”).

10. Keep a record of outcome

The therapist should have some record of outcome (for example by a questionnaire or rating scale) that is specific for OCD.

11. Relationship with your therapist

There should be a good enough relationship with your therapist who you can trust and can support you. You should feel your views are sought and you are involved in the process. The therapist should generally have high expectations about your ability to change. The therapist is always encouraging and positive about your ability to make improvements, seeing problems as a way of learning better ways of dealing with the OCD.

The following are optional but good CBT might also involve:

12. Being asked to listen to recordings of the sessions or keep written summaries of the sessions and your homework.

13. Being recommended or given appropriate reading material to help you further understand what keeps your OCD going.

14. Being asked by your therapist to summarise what you have learned, and other ways of making sure that the therapist and client have some shared understanding of the OCD and how it can be dealt with.

In CBT you would NOT expect to have:

1. Spent most of the sessions talking about your childhood.
2. Spent most of the sessions with your therapist silent.
3. Been encouraged to challenge your thoughts or keep thought records especially when you have intrusive doubts.
4. Been caught up seeking reassurance about your worries or repeatedly been provided with reassurance with your therapist.
5. Been encouraged to try and control, stop or block your intrusive thoughts, images or urges.
6. Been given a mantra or phrase to repeat to yourself or reassure yourself when anxious.
7. Felt that you are being given tasks that you don't understand the rationale for.

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