Understanding OCD

THE TALKING THERAPIES UK SELF-HELP SERIES



Understanding OCD

A six-module psychoeducational programme for adults with obsessive compulsive disorder, oriented towards understanding the condition and preparing for step-3 ERP therapy

A self-help workbook · 6 modules · about 6 weeks

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This workbook accompanies the Understanding OCD programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 12. This printing was set on 17 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this workbook

Obsessive compulsive disorder is one of the most misunderstood psychological conditions in popular culture and one of the most clearly characterised in clinical psychology. The popular image of OCD as a quirk involving tidy desks and an aversion to dirt bears very little resemblance to the actual disorder, which is a deeply distressing condition involving intrusive thoughts the person does not want, anxiety responses to those thoughts that feel out of proportion to anything in external reality, and ritual behaviours that the person knows are excessive but cannot stop. Adults with OCD often spend hours each day captured by the cycle, often hide the extent of it from their families and colleagues, and often go years before they recognise what they have or seek help for it. What this programme is. A six-module psychoeducational programme designed for adults with diagnosed or suspected OCD whose presentation is at the moderate to severe end of the spectrum and who are either seeking individual therapy through the practice or through NHS Talking Therapies, are waiting for therapy to start, or are not yet sure whether what they are experiencing is OCD. The programme covers what OCD actually is, the cognitive-behavioural model that explains why it persists, a mapping exercise to identify your own particular obsessions and compulsions, an explanation of exposure and response prevention (ERP), guidance on how to access step-3 therapy, and a holding plan for the period between recognising the problem and starting treatment. What this programme is not. It is not a substitute for individual therapy. NICE clinical guideline CG31 recommends brief individual cognitive behavioural therapy incorporating exposure and response prevention through self-help materials as the step-2 intervention for adults with mild OCD whose functional impairment is limited. For adults with moderate or severe OCD, which is most adults who recognise the problem and seek help, the recommended intervention is step-3 therapist-led CBT with ERP, typically with a course of ten to twenty sessions. ERP is a powerful intervention but one that requires guidance, particularly in the structuring of an exposure hierarchy, the management of distress during exposures, and the gradual fading of safety behaviours. Attempting full ERP without therapist support can result in poorly-titrated exposures that cause unnecessary distress without producing the cognitive learning that resolves the OCD. This programme therefore explicitly does not attempt to deliver a full ERP protocol; it prepares you for one. The clinical model. The cognitive model of OCD, set out most fully by Paul Salkovskis at the Maudsley in 1985 and refined in subsequent work, holds that OCD does not begin with abnormal thoughts. Intrusive thoughts of an unwanted kind (about contamination, harm, taboo content, doubt, symmetry, sexuality, religion, identity) are universal human experiences. Surveys of people without OCD show that around eighty to ninety per cent of adults report having had intrusive thoughts of exactly the kinds that characterise OCD obsessions, including thoughts of harming loved ones, thoughts about catching disease from public surfaces, and thoughts of a sexual or blasphemous kind that the person finds repugnant. The difference between someone without OCD and someone with OCD is not the presence of the thoughts but the interpretation of them. The person without OCD has the same thoughts, registers them as the random mental noise that they are, and lets them pass. The person with OCD attaches catastrophic personal meaning to the same thoughts (that the thought means I want to do this, that having the thought makes it more likely to happen, that I must do something to make sure it does not happen), and the resulting anxiety drives the compulsions that try to neutralise the meaning. The compulsions

reduce the distress briefly. Each compulsion teaches the brain that the obsession was a real threat and that the compulsion prevented something bad. The threat value of the obsession increases. The cycle accelerates. Treatment. Exposure and response prevention works directly on the cycle. The exposure component deliberately and gradually brings the person into contact with the feared content (the contaminating object, the place where harm-thoughts arise, the situation that triggers checking) without engaging the compulsion. The response prevention component withholds the compulsion that would normally follow. Across repeated exposures, distress at the obsession declines (habituation), the brain learns that the catastrophic interpretation was wrong (cognitive change), and the cycle loses its grip. The protocol is well-evidenced, with outcome studies showing that the majority of adults who complete a full course of ERP achieve substantial and durable reduction in symptoms. The protocol is also demanding and emotionally difficult, which is why having a trained therapist running it is the standard of care for moderate-severe presentations. If at any point during this programme you experience thoughts of harming yourself or others that go beyond the unwanted-intrusive-thought category and feel like genuine intent rather than the egodystonic 'why did my brain produce that' quality typical of OCD, please contact Samaritans on 116 123, text SHOUT to 85258, your GP, or NHS 111 without delay. OCD thoughts and genuine suicidal or violent intent are very different in their qualitative character; if you are unsure which you are experiencing, that uncertainty itself is a reason to talk to a clinician. The practice's therapists are available to discuss whether this programme is the right fit for your particular presentation, and to support you in accessing step-3 care.

This workbook is the written form of the Understanding OCD programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module's teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 6 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

- By the end of this module you will understand the diagnostic definition of OCD, recognise the major subtypes and their commonalities, see how OCD differs from related conditions, and know roughly where your own presentation sits.
- By the end of this module you will understand the Salkovskis cognitive model of OCD, recognise the role of inflated responsibility and thought-action fusion, see how compulsions reinforce obsessions, and understand why the cycle is self-maintaining.
- By the end of this module you will have a written map of your own OCD presentation that is detailed enough to take to a therapy first session: your specific obsessions, the compulsions you perform in response, the situations you have started to avoid, the reassurance-seeking that has crept in, and an estimate of how much daily time the cycle consumes.
- By the end of this module you will understand what ERP is, how it differs from other psychological treatments, why it is effective for OCD across all subtypes, and what a typical course of treatment looks like.
- By the end of this module you will know the routes available to access ERP-based therapy through the practice, the NHS, and private practice, what credentials and experience to look for in a therapist, and how to prepare for a first appointment to make the most of it.
- By the end of this module you will know what helps during the waiting period and what does not, how to handle spikes without making the OCD worse, the markers that indicate stepping up further is needed, and how to maintain hope across what can be a difficult interval.

PART 1

Understanding OCD

What OCD actually is, the major subtypes, and why the popular image is so far from the clinical reality

CHAPTER 1

Welcome to the programme

You are reading this because something in your mental life has become difficult to manage. The thought that keeps coming back, the urge to check or wash or count that you know is excessive but cannot quite resist, the time that disappears into rituals that no one would think were rational from the outside, the secret weight of suspecting that there is something wrong with your mind that you cannot explain to anyone. You may have a diagnosis of OCD already. You may be working with a GP towards a referral. You may be on a waiting list for therapy. Or you may not yet be sure what you have but you have read enough to think OCD might fit.

This is a six-module psychoeducational programme for adults whose presentation is at the moderate to severe end of the spectrum and who are either accessing or preparing to access individual therapy. The work of treating moderate-severe OCD is therapist-led work with a person trained in exposure and response prevention. The work of this programme is everything that surrounds and supports that: understanding what OCD is, why it persists, how it has shaped your particular life, what the treatment actually involves, how to access it, and how to hold steady during the often substantial period between recognising the problem and starting treatment.

A practical note before we begin. OCD is one of the conditions where intellectual understanding lands well but does not, on its own, change the cycle. You will read material in this programme that resonates strongly. You may feel relieved that what you have been experiencing has a name and a model and a treatment. The relief is real. It is not the end of the work. The cycle responds to the experiential work that ERP delivers under therapist guidance. The reading does not, and should not be expected to, eliminate compulsions. What the reading does is prepare you, frame what is to come, and ease the loneliness of having struggled with something that has been hard to name.

If at any point during the programme you experience thoughts of harming yourself, please contact Samaritans on 116 123, text SHOUT to 85258, your GP, or NHS 111. If you are unsure whether a thought is a normal OCD intrusion or a genuine suicidal thought, the uncertainty itself is enough reason to talk to a clinician. OCD thoughts and genuine intent are usually clearly different in quality, but distinguishing them in the moment can be harder than it sounds.

CHAPTER 2

What OCD is, clinically

The diagnostic definition of obsessive compulsive disorder, as set out in DSM-5 and broadly mirrored in ICD-11, has two parts.

Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, and that cause marked anxiety or distress. The crucial word is unwanted. OCD obsessions are by definition egodystonic, meaning they conflict with the person's values, sense of self, and intentions. A father who has a sudden intrusive image of harming his child does not want to harm his child. He is, in fact, the very last person who would harm his child; the image distresses him precisely because it offends against his entire commitment to being a loving father. A devout person who has an intrusive blasphemous thought is not losing their faith; they are someone whose faith is so central to them that an offensive thought is intolerable. The egodystonic quality of OCD obsessions is one of the most reliable diagnostic features and is one of the easiest ways to distinguish OCD from conditions where the thoughts are egosyntonic (in line with values), such as in many forms of antisocial or psychotic presentations.

Compulsions are repetitive behaviours (washing, checking, ordering, repeating actions) or mental acts (praying, counting, repeating words silently, reviewing memories) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly. The compulsions are aimed at preventing or reducing distress, or preventing some feared event or situation; but the compulsions are either not connected in a realistic way to what they are designed to prevent, or they are clearly excessive.

For a diagnosis of OCD, the obsessions or compulsions need to be time-consuming (typically more than an hour a day), cause clinically significant distress, or cause impairment in social, occupational, or other important areas of functioning. The 'one hour a day' threshold is a clinical rule of thumb; many adults with moderate-severe OCD spend far more than an hour each day captured by the cycle, often four to eight hours, sometimes essentially the entire waking day.

OCD affects approximately two to three per cent of the adult population worldwide, making it considerably more common than is generally recognised. The condition typically begins in adolescence or early adulthood, though paediatric and late-onset variants exist. It is roughly equally common in men and women, though the subtype distribution differs: contamination concerns slightly more common in women, harm and sexual obsessions slightly more common in men, with substantial overlap in both directions. It is highly heritable but not deterministic, and the gene-environment interaction that produces the full clinical picture is still being mapped.

A NOTE

OCD obsessions are by definition unwanted. If a thought or urge feels in line with your values and you would act on it given the opportunity, that is not OCD. If a thought or urge feels deeply against your values and the act of having it distresses you, that is far more likely to be OCD. The egodystonic quality is one of the most reliable diagnostic features and one of the most useful for self-recognition.

Mark and Daniel both report having had, in the past month, a vivid intrusive image of pushing a stranger onto train tracks at a busy station. The image is essentially identical in content. The two presentations are otherwise wholly different and illustrate the egodystonic principle.

Mark, 34, primary school teacher. The image arrives while he is standing on the platform at Leeds station. It lasts perhaps two seconds. He is immediately horrified. He steps back from the platform edge, his heart hammering. The thought what does it mean that I had that image arrives almost immediately. He spends the rest of the journey going over it, asking himself whether he is the kind of person who could do such a thing, whether he should be standing back further from the platform in future, whether he should mention it to anyone, whether mentioning it would be evidence that he wanted to do it. By the end of the day he has reviewed the image perhaps thirty times. By the end of the week he is avoiding the underground entirely and is doing a mental check before every train journey to confirm he does not feel any intent. Two months later he has substantially restricted his public-transport use and is spending two to three hours a day on the mental checking. This is the textbook OCD presentation. The image is egodystonic; it appalls Mark precisely because pushing strangers is the opposite of everything Mark stands for; he is in fact a kind, conscientious teacher whose actual safety record around children and the public is exemplary. The compulsions (the mental checking, the avoidance) are the OCD; the thought itself is what most people would call an intrusive thought, the kind that around 90 percent of the adult population reports having at some point.

Daniel, 34, also has the same image while standing on the platform at Leeds station. Daniel notices the image, finds it briefly unpleasant, and forgets about it within thirty seconds. He boards his train and gets on with his day. The image does not return. He does not check anything. He does not avoid stations. He does not spend any further time on it. This is the typical non-OCD response to an intrusive thought of this kind. The image arrived; it was nothing. Most people have these kinds of thoughts; most people do nothing with them.

The difference between Mark and Daniel is not the content of the thought. The content is identical. The difference is the meaning Mark applies to the thought (this might mean something serious about who I am), the distress that meaning produces, and the compulsions Mark performs to manage the distress. The full OCD cycle is the appraisal-plus-compulsion picture, not the thought itself. Module 2 walks through the cognitive model in detail; for now the important point is that intrusive thoughts are universal, and what makes them OCD is what the person does with them.

CHAPTER 3

The major subtypes

OCD presents in a range of subtypes that share the underlying mechanism (obsession leading to compulsion in a self-reinforcing cycle) but differ in the content of the obsessions. Subtype is clinically useful because it shapes the specifics of treatment, particularly the design of the exposure hierarchy in ERP. The major subtypes are as follows; many people have more than one.

Contamination OCD. Obsessions about dirt, germs, bodily fluids, chemicals, or disease, leading to compulsive washing, cleaning, avoidance of touching things, and elaborate rituals around hand-washing or showering. The contamination fear can be physical (germs) or symbolic (moral contamination, where touching a person or object associated with something the person finds morally repugnant produces the same distress as physical contamination). This is the popular stereotype of OCD; it is one subtype among many, and it affects approximately one quarter of OCD patients.

Checking OCD. Obsessions about responsibility for harm, leading to compulsive checking of locks, taps, hobs, electrical devices, that you have locked your car, that you have not run someone over while driving, that you have not made a mistake at work that will hurt someone. The checking can take hours and the person often re-checks the same thing many times, with each check undermined by the doubt that they did not really see what they thought they saw.

Symmetry, ordering, and 'just right' OCD. Obsessions about things being arranged correctly, evenly, symmetrically, or in a way that feels right, leading to compulsive arranging, ordering, repeating actions until they feel right, and counting. This subtype overlaps with what is sometimes called tic-related OCD and is more common in men and in younger-onset cases.

Taboo intrusive thoughts. Obsessions involving violence, sexuality (often involving children, family members, or same-sex content in someone otherwise straight, or vice versa), religion (blasphemy, fears of having sinned), or harm to loved ones. The compulsions are typically mental (reviewing whether you really might have done or wanted something, praying, mental neutralising), often combined with avoidance of situations that could trigger the thoughts and reassurance-seeking from others. This subtype, sometimes called Pure-O (purely obsessional) though it always involves compulsions, is one of the most distressing and one of the most under-recognised; many adults with taboo-thought OCD go decades before recognising what they have, partly because they are too ashamed to describe the thoughts to anyone.

Health OCD (sometimes called health anxiety). Obsessions about having or developing a serious illness, leading to compulsive body-checking, reassurance-seeking from doctors and the internet, and avoidance of triggers. This subtype overlaps with what DSM-5 separately classes as illness anxiety disorder; the boundary is fuzzy.

Relationship OCD (ROCD). Obsessions about the rightness of one's relationship, whether one really loves the partner, whether the partner is really attractive enough or right enough, leading to compulsive mental review, comparison, reassurance-seeking, and avoidance of intimacy or commitment.

Existential OCD. Obsessions about the nature of reality, consciousness, meaning, or one's own identity, leading to compulsive philosophical reasoning that can fill hours and never reaches resolution.

Scrupulosity. Religious or moral OCD, where obsessions concern having sinned, having failed in religious duty, or being a bad person, leading to confession rituals, prayer rituals, and constant moral self-examination.

Most adults with OCD have a primary subtype with secondary features from other subtypes. The subtypes share the underlying mechanism and respond to the same treatment principles; ERP is the first-line treatment for all of them. Module three of this programme will guide you through mapping your own subtype pattern in detail.

CHAPTER 4

OCD versus what it is not

A few clarifications about what OCD is and what it is not, because confusion about this is common and matters for treatment.

OCD is not the same as being tidy or organised. The casual use of 'I am so OCD about my desk' is a category error. Preferring an organised desk is a personality preference. OCD is a clinical condition involving distressing obsessions, time-consuming compulsions, and significant impairment in daily life.

OCD is not the same as Obsessive Compulsive Personality Disorder (OCPD). OCPD is a personality disorder characterised by perfectionism, rigidity, and preoccupation with rules and orderliness, where the person typically does not experience their traits as distressing or excessive. People with OCPD usually do not seek treatment because they do not see the traits as a problem; people with OCD almost always recognise their compulsions as excessive and want to stop. The conditions are distinct, can co-occur, but should not be conflated.

OCD is not psychosis. The intrusive thoughts in OCD, even the most graphic and disturbing taboo content, are recognised by the person as their own thoughts rather than externally-imposed voices or beliefs about reality that conflict with what is actually happening. A person with OCD who has the thought 'what if I push this person in front of the train' knows that the thought is a thought and finds it horrifying; they have no actual intent and no actual belief that someone is making them do it. This is qualitatively different from psychotic experience and OCD does not develop into psychosis.

OCD is not the same as autism, though there is real overlap in some presentations, particularly around repetitive behaviours and rigid routines. The differential is usually clear on a careful clinical history. Autism-related routines are typically calming and chosen rather than driven by distressing intrusive thoughts; OCD compulsions are driven by anxiety in response to obsessions and the person typically wishes they did not need to do them.

OCD is not the same as a personality flaw or a sign that something is wrong with you morally. The taboo content of some OCD subtypes can make sufferers feel that the very fact of having such thoughts proves they are bad people. This is the OCD itself talking. The content of the thoughts is universal human cognitive noise; what makes it OCD is the meaning the person attaches to it, and the attached meaning is itself a feature of the disorder rather than a true insight into one's character. People with harm-OCD do not harm people. People with paedophilic-themed OCD are not paedophiles. People with religious-OCD are not less devout than anyone else; they are usually more so. The thoughts are not the person.

WORKSHEET

Sort each presentation into the OCD subtype it represents

Before writing your own pattern description in plain language, sort fourteen OCD presentations by which of the seven major subtypes each one most closely matches. Most adults with OCD have a primary subtype with secondary features from one or two others; the exercise asks you to identify the dominant subtype in each example. Recognising the subtypes builds the working language that the recognition exercise and any future therapy assessment will use, and the discrimination matters because the subtype shapes the specifics of treatment, particularly the design of the exposure hierarchy in ERP. The under-recognised subtypes (taboo intrusive thoughts, relationship, existential, scrupulosity) deserve particular attention because adults with these presentations often go years before recognising what they have.

Contamination OCD involves obsessions about dirt, germs, bodily fluids, chemicals, disease, or moral contamination, leading to compulsive washing, cleaning, and avoidance. Checking OCD involves obsessions about responsibility for harm, leading to compulsive checking of locks, hobs, taps, electrical devices, that you have not run someone over while driving, or that you have not made a mistake. Symmetry, ordering, and just-right OCD involves obsessions about things being arranged correctly, leading to compulsive arranging, repeating actions until they feel right, counting. Taboo intrusive thoughts (sometimes called Pure-O) involve obsessions about violence, sexuality, religion, or harm to loved ones, with mostly mental compulsions of reviewing, neutralising, and reassurance-seeking. Relationship OCD involves obsessions about the rightness of the relationship, whether one really loves the partner, with compulsive mental review and comparison. Existential or scrupulosity OCD involves obsessions about reality, consciousness, meaning, religious duty, or being a bad person, leading to compulsive philosophical reasoning or moral self-examination. Health OCD involves obsessions about having or developing serious illness, leading to compulsive body-checking and medical reassurance-seeking.

The groups: A Contamination OCD B Checking OCD C Symmetry, ordering, and just-right OCD D Taboo intrusive thoughts E Relationship OCD F Existential or scrupulosity OCD G Health OCD

Write the letter of the group each item belongs to in its box.

☐ 1. A forty-minute hand-washing ritual after handling shopping, with each finger washed individually in a precise order, and the sense that any skipped step has invalidated the whole sequence

☐ 2. Returning to the house three times after locking up to verify the back door, the hob, and the front door, with the doubt re-arriving as soon as I have walked twenty yards from the house

☐ 3. A felt-need for the books on the shelf to be exactly aligned by spine height, with the wrong arrangement producing a “not-right” sensation that persists until the books have been re-ordered

☐ 4. Intrusive images of violently harming my children that arrive several times a day, leading to extensive mental review of whether I might really want to do this and to avoidance of being alone with them

- [ ] 5. Hours of mental review every day asking whether I really love my partner, whether the relationship is right, whether I am with the wrong person, with no answer holding for longer than a few hours
- [ ] 6. Compulsive online searching for information about a symptom I have been having, multiple appointments with the GP across the past three months despite reassurance, body-checking several times a day
- [ ] 7. Avoidance of touching public surfaces, doorknobs, and shared keyboards, with handwashing rituals taking up to two hours a day and skin damage from the frequency of washing
- [ ] 8. Compulsive checking of the rear-view mirror while driving to confirm I have not run someone over, with the doubt that I have hit a pedestrian arriving repeatedly during ordinary urban driving
- [ ] 9. Walking around the room until each step feels symmetrical, redoing the journey across the living room until both feet have landed an equal number of times, with the felt-need to repeat until it is right
- [ ] 10. Intrusive blasphemous thoughts during prayer that I am terrified mean I am secretly possessed or have lost my faith, leading to extensive prayer rituals and mental neutralising that take hours of each day
- [ ] 11. Compulsive comparison of my partner to other people we encounter, scanning their face for any sign of attractiveness mismatch, mentally reviewing whether the partnership is the right one
- [ ] 12. Long stretches of compulsive philosophical reasoning about whether other people are conscious, whether my own consciousness is real, whether the world is as it appears, the reasoning never reaching resolution
- [ ] 13. A persistent intrusive thought that I will push my colleague in front of the train at the platform tomorrow morning, leading to avoidance of standing near the platform edge and mental review of whether the thought means anything
- [ ] 14. Repeated checks of breast tissue for lumps multiple times a day, daily online searching about cancer symptoms, three GP appointments in the past two months despite negative imaging results

The answers are at the back of the book.

WORKSHEET

Recognising your own pattern

Take fifteen minutes. Write a brief description in your own words of what your OCD looks like, in plain language as you would describe it to a trusted friend or to a therapist. Try to address:

What are the main obsessions or intrusive thoughts? What content do they have? When did they start?

What are the main compulsions or rituals? What do you do, mentally or physically, in response to the obsessions?

Which of the major subtypes from the previous block does your presentation most closely match? It is fine if you have features of more than one.

How many hours each day, roughly, does the cycle take? Include physical compulsions, mental

compulsions, avoidance, and reassurance-seeking.

How long has this been going on?

What triggered seeking help, or led you to recognise it might be OCD?

What have you tried so far?

This description is for you. It is also a useful document to take to a first therapy appointment if you are accessing one; therapists routinely ask the same questions and having your answers written down can ease what is often a difficult conversation to open.

Describe your own OCD presentation in plain language.

CHAPTER 5

What you have done in this module

You have a working clinical definition of OCD as the combination of intrusive egodystonic obsessions and the compulsions that arise in response to them. You can name the major subtypes and recognise your own predominant pattern. You can distinguish OCD from related conditions including OCPD, psychosis, autism, and from simple personality preferences for tidiness. You have a written description of your own presentation that you can use as a starting point for therapy access conversations.

The next module covers the cognitive-behavioural model of why OCD persists and why the obvious-seeming solution of 'just stop doing the compulsions' does not work without structured help.

CHECK-IN

Mood check-in (PHQ-9)

Before you begin, take a few minutes to complete this short questionnaire. It is the same one used in NHS Talking Therapies and gives us a baseline against which to measure your progress over the programme.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total: _____ Date: _____

Add up the numbers you have circled. A total of 0 to 4 suggests minimal symptoms of depression, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe. Note your total and the date, so you can compare the next check-in with this one.

If you circled anything other than 0 for the last question, please talk to your GP or call NHS 111 today. If you are in danger now, call 999.

The PHQ-9 and GAD-7 were developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute them.

CHECK-IN

Everyday life check-in (WSAS)

And one more short questionnaire about how things are affecting everyday life: work, home, social life, relationships and leisure. Functioning often recovers on a different timetable to symptoms, and it matters just as much.

This check-in uses the WSAS (Work and Social Adjustment Scale). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.

WORKSHEET

Taking this forward

Before you move on, take two minutes to make this module harder to lose. Skills fade fastest in exactly the moments they are needed most, so the work here is to decide now, while things are steady, what you will reach for when they are not.

If things ever feel much worse rather than better, that is a signal to reach out rather than push on alone: use the messaging button to contact the practice, speak to your GP, or if you feel unsafe right now contact 999 or the Samaritans on 116 123.

Three short answers, in your own words. First: what single idea or skill from this module do you most want to keep? Second: when, realistically, will it be hardest to use, name the actual situation. Third: what exactly will you do in that moment? Write it as a sentence you could follow when stressed.

PART 2

Why OCD Persists

The cognitive-behavioural model of OCD and why simply trying to stop the compulsions does not work

CHAPTER 6

Salkovskis's cognitive model in compressed form

Paul Salkovskis published the cognitive model of OCD in 1985 in the journal Behaviour Research and Therapy. The paper, and the subsequent refinements over the following decade, transformed the clinical understanding of OCD. The model has five steps.

Step one. An intrusive thought arrives in consciousness. Intrusive thoughts of the kind that fuel OCD obsessions are universal human cognitive events. Research surveys conducted across the 1980s and 1990s, asking large samples of adults without OCD whether they ever experienced intrusive thoughts of a graphic, violent, sexual, or distressing kind, consistently produced positive responses from around eighty to ninety per cent of respondents. The contents reported by non-OCD adults are the same contents that constitute OCD obsessions: thoughts of harming family members, fears of contamination from public surfaces, blasphemous thoughts in religious people, sexual thoughts in people whose orientation does not match the thought, doubts about whether the door is locked even when it has just been checked. The thoughts are normal mental noise produced by a brain that is constantly generating possibilities, threats, and associations.

Step two. The thought is appraised. This is where the model becomes interesting. In a person without OCD, the appraisal is roughly: that was an odd thought, my brain is strange, oh well, moving on. In a person with OCD, the appraisal carries weight: that thought means something about me, having the thought makes the feared thing more likely, I am responsible for what happens next, I must do something to prevent the feared outcome. Several specific appraisal patterns produce OCD. Salkovskis put the first of the three below at the centre of his model, and the researchers who built on his work, Stanley Rachman and his colleagues among them, described the other two: inflated responsibility (I am specifically responsible for preventing harm to myself or others), thought-action fusion (having the thought is morally equivalent to performing the action, or makes the action more likely to happen), and overestimated importance of thoughts (this thought is important, otherwise I would not be having it).

Step three. The appraisal produces distress, typically anxiety, often with a specific moral or shame component (guilt for having the thought, fear of being a bad person, fear of being responsible for harm). The distress is the engine of what follows.

Step four. The person performs a compulsion to neutralise the distress. Compulsions can be overt (washing, checking, ordering, repeating actions) or covert (mental review, counting, praying, suppressing the thought, replacing the bad thought with a good one). The compulsion is selected based on what the person believes will undo the threat: hand-washing for contamination, checking for harm-by-negligence, reassurance-seeking for relationship doubt. The compulsion temporarily reduces the distress.

Step five. The cycle reinforces. The brain registers two things. First, the distress reduced after the compulsion, so the compulsion appears to have worked. Second, the predicted catastrophe (which was never actually going to happen) did not happen, which the brain attributes to the compulsion rather than to the catastrophe never having been real. The next time a similar intrusion arrives, the catastrophic appraisal fires more readily, the distress is higher, the urge to compulse is stronger, and the loop runs faster.

Across weeks and months and years, the cycle entrenches. The obsessions become more frequent and more distressing. The compulsions become more elaborate and more time-consuming. The avoidance widens. The person's life shrinks around the things they can no longer do without triggering the cycle.

A NOTE

OCD is maintained by the meaning attached to intrusive thoughts, not by the thoughts themselves. The cognitive model's central insight is that the thoughts are normal; the disorder lies in the appraisal of the thoughts and in the compulsions that follow from the appraisal. Treatment works by changing both.

The end of the sample

This is a free sample of "Understanding OCD", and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

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