Understanding OCD: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Understanding OCD: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 6 contacts · to accompany the workbook

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

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

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 7. This printing was set on 9 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

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

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How to use this guide

This guide is for qualified practitioners who support clients through the Understanding OCD programme as guided self-help: a short supported contact after each of its 6 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 6 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: what OCD is and is not, the universality of intrusive thoughts, the cognitive model and its appraisal patterns, why the programme prepares for treatment rather than delivering it, how the six modules are built, and the practitioner's part
- Chapter 2, What the research shows: how common OCD is, why people wait years for help, the evidence for exposure and response prevention and for medication, what is known about self-help for OCD and about early low-intensity help, families and accommodation, the risk of suicide, and the national guidance

CHAPTER 1

The model behind the programme

A programme that prepares for treatment

Understanding OCD is unusual among the practice's programmes, and the practitioner needs to hold its purpose clearly from the first contact. It is written for adults whose OCD is at the moderate to severe end of the range and who are seeking, waiting for, or not yet sure they need, therapist-led cognitive behavioural therapy with exposure and response prevention. Its description says plainly that it is not a substitute for that therapy and that it does not attempt to deliver a full exposure protocol; it prepares the client for one. The six modules cover what OCD is, why it persists, a written map of the client's own OCD, what exposure and response prevention involves, how to reach a therapist who offers it, and a holding plan for the period before treatment begins.

The practical consequence for the practitioner is a discipline that runs through every contact. Supporting this programme means helping the client understand, map, prepare and hold steady. It does not mean setting exposure homework, building a hierarchy, or encouraging the client to resist compulsions on a schedule of the practitioner's devising. The programme gives its reason: exposure carried out without a trained therapist to structure the hierarchy, manage the distress and fade the safety behaviours can produce badly paced exposures that cause distress without the learning that resolves the OCD. Where a client asks to start exposure work now, the right answer is to help them reach the treatment that provides it.

What OCD is

Module 1 teaches the diagnostic definition as DSM-5 sets it out and ICD-11 broadly mirrors it. Obsessions are recurrent, persistent thoughts, urges or images that are experienced as intrusive and unwanted and that cause marked anxiety or distress; the person tries to ignore, suppress or neutralise them. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession or by rigid rules, aimed at preventing distress or a feared event, and either not realistically connected to it or clearly excessive. The module adds the threshold that makes this a disorder rather than a habit: the cycle takes a great deal of time, typically more than an hour a day, or causes clinically significant distress or impairment.

The feature the practitioner will return to most often is that obsessions are unwanted. The module puts it in a call-out: if a thought or urge fits the person's values and they would act on it given the chance, it is not an obsession. The content of obsessions is commonly the opposite of what the person wants, which is why it horrifies them, and why the gentle parent has intrusive images of harming their child and the devout person has blasphemous thoughts in prayer. The module illustrates the subtypes (contamination, checking, symmetry and "just right" experiences, taboo intrusive thoughts, health-focused, relationship, existential and scrupulosity), notes that most adults have a primary subtype with features of others, and stresses that the subtypes share one mechanism and respond to the same treatment.

The module also says what OCD is not: tidiness or a liking for order, obsessive compulsive personality disorder (in which the traits are valued rather than resisted), psychosis (the person recognises the thoughts as products of their own mind), or a moral failing. On autism it is careful, noting real overlap in repetitive behaviour and rigid routine and a different function: in OCD the behaviour neutralises a feared meaning, while autistic routines more often bring comfort or predictability in their own right. Health-focused OCD needs one clarification. The module calls it "sometimes called health anxiety"; the two overlap, and ICD-11 places hypochondriasis in the same chapter as OCD, but where the client's difficulty is chiefly the fear of having a serious illness, with checking and reassurance seeking about symptoms, the practice's Managing Health Anxiety programme is usually the better fit.

Intrusive thoughts are almost universal

The programme's whole model rests on a finding that many clients find hard to believe at first: unwanted intrusive thoughts of the kind that fill obsessions are part of ordinary mental life. Rachman and de Silva (1978) found that most of a non-clinical sample reported intrusive thoughts, and that their content was much like that of patients' obsessions; what differed was that the patients' thoughts were more frequent, more intense, longer-lasting and harder to dismiss. A study across thirteen countries on six continents found that the great majority of participants had experienced at least one unwanted intrusive thought in the previous three months (Radomsky et al., 2014). The programme's description gives a figure of around eighty to ninety per cent, which is consistent with that literature.

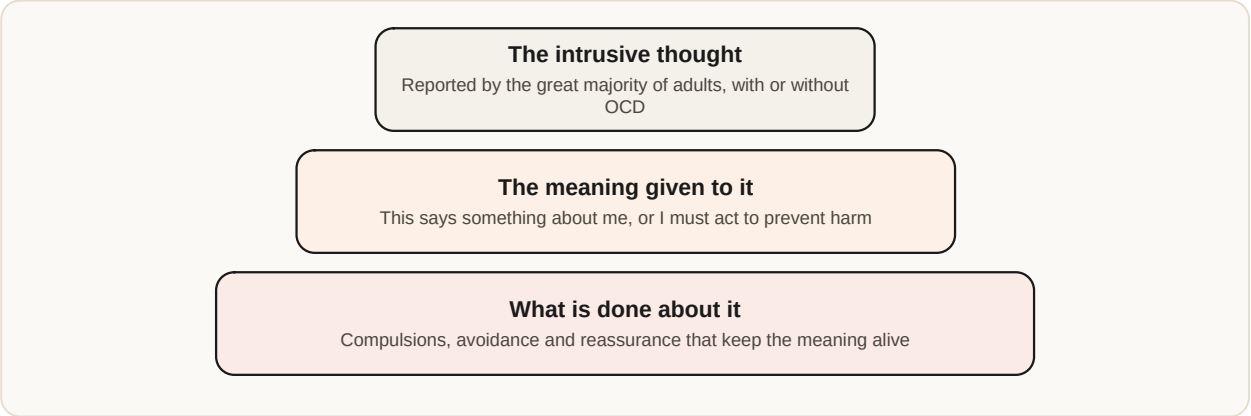


FIGURE 1.1 Where OCD begins: not in the thought, but in its meaning
Module 1 makes the point through Mark and Daniel, who have the same intrusive image on the same platform. Unwanted intrusions are almost universal; what turns one into an obsession is the meaning given to it, and what keeps the obsession alive is what is done to neutralise it.

Module 1 makes the point through Mark and Daniel, two men of thirty-four who have the same vivid image of pushing a stranger onto the tracks at Leeds station. Daniel finds it unpleasant and forgets it. Mark is horrified, wonders what the image says about him, stands well back from the platform edge and reviews it for days. The difference is not the content of the thought, which is identical, but the meaning attached to it. That one example carries the central message of the programme, and the practitioner should be ready to return to it whenever a client says that their thoughts prove they are dangerous.

The cognitive model

Module 2 sets out the cognitive model that Salkovskis (1985) proposed in Behaviour Research and Therapy. An intrusive thought arrives; it is appraised as meaningful and dangerous; the appraisal produces distress; the person performs a compulsion or neutralising act to reduce the distress or prevent the feared outcome; and the cycle is reinforced. Two things are learned each time. The relief that follows the compulsion makes the compulsion seem to have worked, and because the feared outcome is never allowed to fail to happen, the appraisal is never tested. Across months and years the intrusions grow more frequent, the compulsions more elaborate, and the life around them narrower.

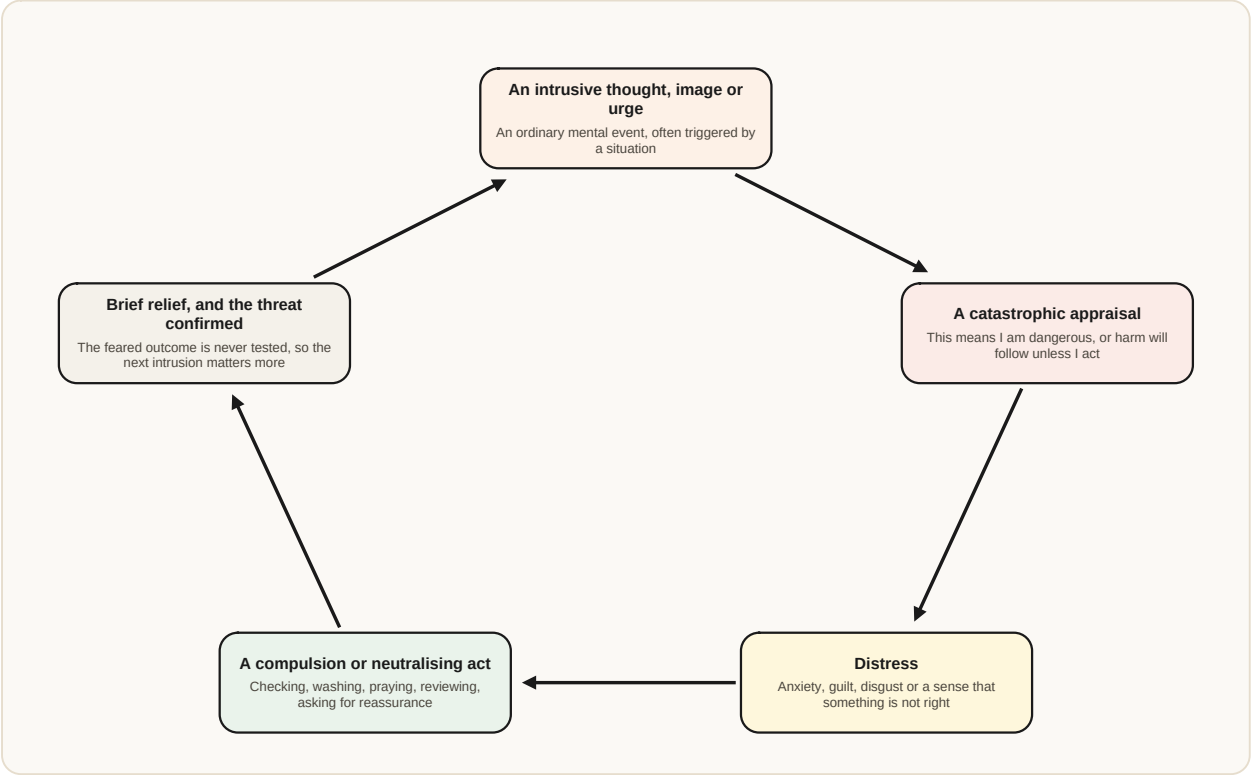


FIGURE 1.2 The cycle that keeps OCD going
Module 2 sets out the cognitive model in five steps. The compulsion brings relief, so it seems to have worked; it also prevents the person from learning that the feared outcome would not have happened, so the intrusion returns with more threat attached and the cycle tightens.

The module's call-out states the model's core: OCD is maintained by the meaning attached to intrusive thoughts, not by the thoughts themselves. This matters for the practitioner's stance. Arguing with the content of an obsession ("you would never do that") is itself a form of reassurance, and it has the same short life as any other.

Responsibility and thought-action fusion

Module 2 then names three appraisal patterns, inflated responsibility and the two forms of thought-action fusion, and asks the client to find which is doing most of the work in their own OCD. Inflated responsibility is the belief that one has power to bring about or prevent harm, and that failing to prevent it would be as bad as causing it; it is the centre of Salkovskis's account, and Salkovskis and colleagues (2000) showed that responsibility attitudes and interpretations distinguish people with OCD from people with other anxiety disorders and from controls. Thought-action fusion has two forms: the moral form, in which having an unacceptable thought is felt to be morally equivalent to acting on it, and the likelihood form, in which thinking about an event is felt to make it more likely. These were described by Rachman (1993) and measured by Shafran, Thordarson and Rachman (1996). The module gives each pattern its source, Salkovskis for inflated responsibility and Rachman and his colleagues for thought-action fusion, and presents them as parts of one cognitive account, which is how treatment uses them.

What keeps the cycle going

Three behaviours do most of the maintaining, and the practitioner will meet all three in every client. Compulsions, overt and covert, are the most obvious. Avoidance is the quietest: the module calls it the slowest-growing component of OCD and the easiest to extend without noticing, and it often goes unreported because it feels like sensible caution. Reassurance seeking is the one most likely to involve the practitioner. People with OCD seek reassurance more intensively and more carefully than people with panic disorder, and are more likely to reassure themselves (Kobori and Salkovskis, 2013). Each answer eases the doubt briefly and teaches that the doubt needed answering, so the question returns. A practitioner who answers the same question at every contact has become part of the OCD.

Attempts to push the thoughts away make matters worse rather than better. Wegner and colleagues (1987) showed that trying to suppress a thought led to a later rebound in its frequency, and a meta-analysis of controlled studies found a small to moderate rebound effect overall (Abramowitz, Tolin and Street, 2001). Module 6 draws on this when it lists trying never to have the thoughts among the things that do not help during the wait.

How the programme works

Module 1 gives the definition, the subtypes and the boundaries, and asks the client to describe their own pattern in writing. Module 2 teaches the model and asks the client to walk one obsession through it. Module 3 builds a four-section map of obsessions, compulsions, avoidance and reassurance, with an honest estimate of the daily time the cycle takes. Module 4 explains exposure and response prevention, what a course of therapy looks like, and where medication fits. Module 5 covers the routes into therapist-led treatment and how to prepare for a first appointment. Module 6 builds a holding plan for the wait and sets out the markers that mean the wait is not safe.

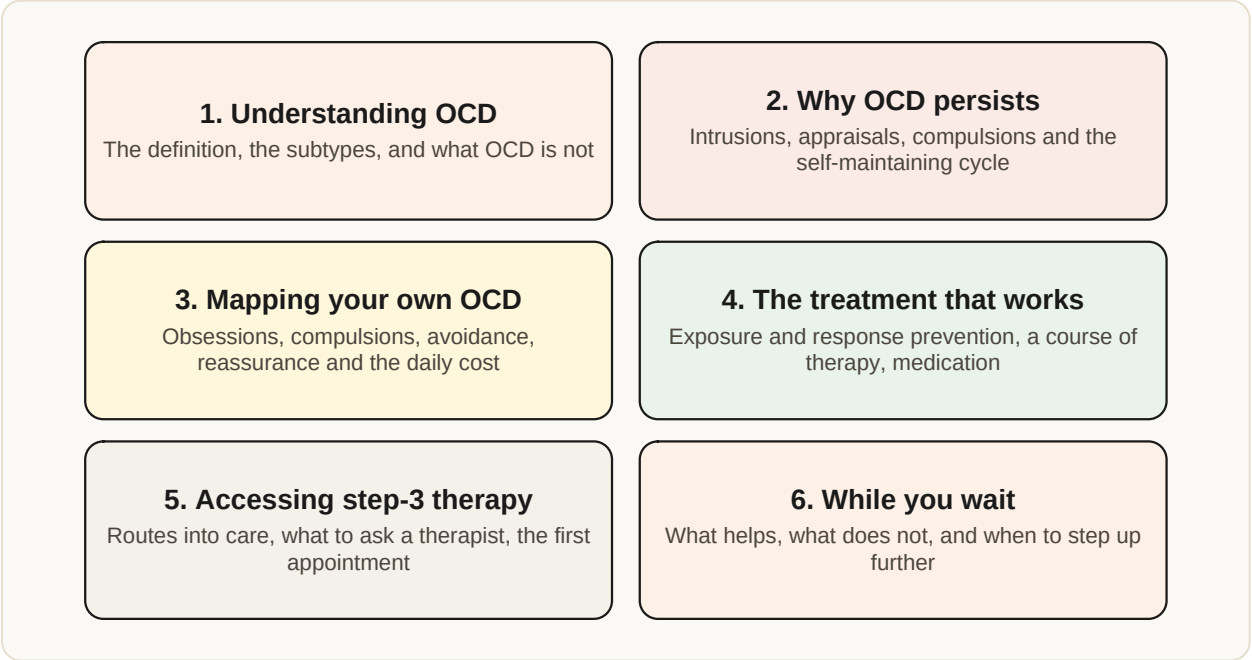


FIGURE 1.3 The six modules and what each works on
The programme moves from understanding to preparation: what OCD is, why it persists, a written map of the client's own OCD, what exposure and response prevention involves, how to reach a therapist who offers it, and a plan for holding steady until treatment begins.

How the modules are built

Each module has two to four teaching sections, a worked example, a sorting exercise, a written exercise and the closing reflection "Taking this forward"; module 6 also carries a short list of further reading. The sorting exercises carry much of the teaching, and their answers and reasons print in this guide. The check-ins come in modules 1, 3 and 6: the PHQ-9 and the Work and Social Adjustment Scale in module 1, and the PHQ-9, GAD-7 and WSAS in modules 3 and 6. Take the GAD-7 at assessment too, since the programme does not ask for it until module 3.

None of these measures OCD itself. Add the Obsessive-Compulsive Inventory, revised, an eighteen-item self-report measure whose total runs from 0 to 72 and whose six subscales (washing, checking, ordering, obsessing, hoarding and neutralising) show where the difficulty lies (Foa et al., 2002); it is the measure NHS Talking Therapies services use for OCD, so a step-3 therapist will recognise it. Take it at assessment and at contacts 3 and 6. The Yale-Brown Obsessive Compulsive Scale, a clinician-rated interview (Goodman et al., 1989), is the standard measure in treatment trials and is what many step-3 therapists will use at their own assessment; it belongs to the therapist rather than to this programme.

Read the scores honestly. A psychoeducational programme is not expected to bring about reliable change in OCD symptoms, and a client whose scores barely move may still have done exactly what the programme asks: understood the OCD, mapped it, prepared for treatment and held their ground. The worked examples in this guide follow one composite client, Leah, through all six contacts.

What the practitioner adds

The programme carries the teaching. The practitioner's part has three demands that are particular to OCD.

The first is to hold the line between preparing and treating. The practitioner explains, normalises, helps the client map and plan, and keeps them moving towards therapist-led treatment; they do not run exposures, devise response prevention targets, or challenge the content of obsessions. The holding plan in module 6 does include some limits (no new avoidance, reassurance seeking reduced by agreement), and supporting those is part of the role, but the line is crossed when the practitioner starts grading and assigning exposures.

The second is to understand intrusive thoughts well enough to assess risk accurately. Clients with harm-related, sexual or blasphemous obsessions have often waited years to say them aloud, and a practitioner who reacts with alarm can confirm their worst fear and end the work. NICE advises that where a professional is uncertain about the risks associated with intrusive sexual, aggressive or death-related thoughts, they should consult a clinician with specific expertise in OCD, and notes that these themes are common in OCD and often misinterpreted as indicating risk. At the same time, OCD carries a raised risk of suicide, and the practitioner asks about it at every contact (Chapter 10).

The third is to keep the route to treatment open and moving. The evidence on low-intensity work for OCD, set out in the next chapter, suggests that early low-intensity help can reduce how many people go on to take up the therapist-led treatment they need. The practitioner's measure of a good outcome is therefore a client who reaches that treatment prepared, not a client who decides they no longer need it. Chapter 5 shows how a thirty-minute contact can hold all three demands.

CHAPTER 2

What the research shows

How common OCD is

In the National Comorbidity Survey Replication, a nationally representative survey of adults in the United States, the lifetime prevalence of DSM-IV OCD was 2.3 per cent and the twelve-month prevalence 1.2 per cent (Ruscio et al., 2010). More than a quarter of respondents reported obsessions or compulsions at some point in their lives without meeting the full criteria, which fits the cognitive account of intrusions as part of ordinary experience. The same survey found substantial comorbidity, not only with anxiety and mood disorders but with impulse-control and substance use disorders, and found that more severe OCD was associated with poorer role functioning. The programme's figure of two to three per cent describes the lifetime figure; at any one time the figure is nearer one in a hundred.

Why people wait years for help

Most people with OCD wait a long time before they seek help, and many never do. A review of the reasons found shame and fear of what others will think, worries about how professionals will react to the content of obsessions, not knowing that the symptoms are part of a recognised and treatable disorder, and practical barriers of cost and access (García-Soriano et al., 2014). The practitioner meets clients at the end of that delay, which is why the first contact's tone matters so much. A client who discloses the thought they have never told anyone, and finds the practitioner calm and unsurprised, has taken the first step of treatment before treatment has begun.

The evidence for exposure and response prevention

Cognitive behavioural therapy with exposure and response prevention is the best-established psychological treatment for OCD. A meta-analysis of sixteen randomised controlled trials with 756 participants found that CBT outperformed control conditions with a large effect at the end of treatment (Hedges' g = 1.39), and that neither the severity of OCD nor depression before treatment significantly reduced the effect (Olatunji et al., 2013). In a large randomised controlled trial, intensive exposure and ritual prevention, alone or combined with clomipramine, was more effective than clomipramine alone, and all active treatments were more effective than placebo (Foa et al., 2005). A clinical review in JAMA summarised the position: CBT with exposure and response prevention and the serotonin reuptake inhibitors are the first-line treatments, with augmentation strategies for those who do not respond (Hirschtritt, Bloch and Mathews, 2017).

How exposure works has been rethought in the last two decades. The programme's description speaks of habituation, the fall in distress across repeated exposures, alongside the cognitive change of learning that the feared appraisal was wrong. The inhibitory learning account holds that what matters most is the learning that occurs when an expectation is violated, rather than how far distress falls within a session, and that the new learning competes with the old threat association rather than erasing it (Craske et al., 2014). For the practitioner the practical consequence is modest: a client who has read that distress must fall before an exposure counts can be told that

therapists now attend at least as much to what was learned as to how quickly distress subsided.

Medication

Module 4 describes the serotonin reuptake inhibitors as the first-line medication for OCD, typically at higher doses than for depression and with a longer wait for benefit. A Cochrane review of seventeen trials found the SSRIs more effective than placebo in reducing OCD symptoms, with more adverse effects than placebo (Soomro et al., 2008). Medication is the GP's or psychiatrist's decision with the client, and the module says so. The practitioner's part is to make sure the client knows it is an option, to help them prepare questions for their GP if they want to discuss it, and never to advise on starting, changing or stopping a medicine.

What is known about self-help for OCD

Self-help has a respectable literature in OCD, and the amount of contact with a clinician matters. An early review found that self-help with minimal therapist contact could produce useful improvement for some people with OCD (Mataix-Cols and Marks, 2006). A later meta-analysis of eighteen studies with 1,570 participants found an average effect of g = 0.51 for self-help interventions, with large effects for self-help with minimal therapist contact (g = 0.91), moderate effects for predominantly self-help (g = 0.68) and small effects for self-administered self-help with no contact (g = 0.33), while cautioning about the variety of approaches and the risk of bias in the studies (Pearcy et al., 2016). Delivery at a distance can work: in a randomised non-inferiority trial, CBT with exposure and response prevention delivered by telephone was as effective as face-to-face treatment (Lovell et al., 2006). Those findings concern self-help that includes exposure work. This programme deliberately does not, so the literature supports its contacts but not any expectation that the programme alone will relieve moderate to severe OCD.

What early low-intensity help can do to the route into treatment

One trial bears directly on what this programme does. In the OCTET trial, 473 adults on waiting lists for therapist-led CBT in UK services, most with severe OCD, were randomised to supported computerised CBT, guided self-help with written materials, or the waiting list alone (Lovell et al., 2017). At three months guided self-help produced a modest reduction in OCD symptoms that did not reach the trial's prespecified level of clinically significant benefit; computerised CBT produced none; and at twelve months neither differed from the waiting list. Early low-intensity help reduced the uptake of therapist-led CBT over the year: 86 per cent of those on the waiting list alone had started high-intensity treatment by the end of the trial, against 62 per cent of those offered computerised CBT and 57 per cent of those offered guided self-help. Longer-term outcomes were not compromised in the trial, but the authors concluded that low-intensity interventions did not lead to clinically significant benefits and might reduce uptake of therapist-led CBT.

That finding shapes how this programme should be supported. The practitioner protects the client's place on any waiting list, treats the programme as preparation for treatment rather than an alternative to it, and returns at every contact to the access plan. A client who feels better after six weeks of understanding and holding has gained something real, and still has the disorder that therapist-led treatment is best placed to change.

Families and accommodation

Family members often accommodate OCD: answering the same questions, checking on the person's behalf, changing routines, avoiding triggers for them or joining in rituals. A meta-analysis of forty-one studies found a moderate association between family accommodation and OCD severity (r = .42), and accommodation has been linked to greater impairment and a poorer response to treatment (Wu et al., 2016). NICE recommends considering involving a family member or carer as a co-therapist in exposure work where that is appropriate and acceptable. In this programme the family's part is narrower: understanding the OCD, agreeing limits on reassurance as the holding plan in module 6 suggests, and not adding new accommodations during the wait.

The risk of suicide

OCD carries a raised risk of suicide that clinicians have long underestimated. In a population study of 36,788 Swedish patients with OCD, the unadjusted risk of death by suicide was almost ten times that of matched controls, and the risk remained substantial after adjusting for other psychiatric conditions; a previous suicide attempt was the strongest predictor of death by suicide, and comorbid personality and substance use disorders raised the risk further (Fernández de la Cruz et al., 2017). NICE asks clinicians to assess the risk of self-harm and suicide in people with OCD, especially where depression is also present, and to include the impact of compulsive behaviour on the person and on others. Module 6 lists suicidal thinking that is more than fleeting, self-harm, severe depression and worsening substance use among the markers for stepping up, and the practitioner asks about suicidal thoughts at every contact.

Harm-related intrusions and risk

The opposite error, treating an obsessional intrusion as evidence of danger, is just as important to avoid. Intrusive thoughts of harming others, of sexual acts or of blasphemy are among the commonest obsessions, and they are characteristically unwanted, distressing and resisted. A review of risk assessment in OCD advises clinicians to distinguish such thoughts from the rare cases of genuine intent by their quality (ego-dystonic, resisted and accompanied by neutralising and avoidance) and to consider the factors that raise risk in anyone, such as a history of violence, substance misuse, psychosis or thoughts the person welcomes, rather than the content of the obsession (Veale et al., 2009). NICE makes the same point and advises consultation with a clinician expert in OCD when there is uncertainty. A safeguarding referral made solely because a parent has unwanted intrusive thoughts about harming their child is likely to cause harm; a practitioner who has any genuine concern about a child's welfare follows their service's safeguarding procedures as for any other client (Chapter 10).

The national guidance

The guidance the programme refers to is the National Institute for Health and Care Excellence (2005) guideline on obsessive-compulsive disorder and body dysmorphic disorder, which NICE last reviewed in 2024. For adults with mild functional impairment, or who prefer a low-intensity approach, it recommends low-intensity CBT including exposure and response prevention, of up to ten therapist hours, delivered as brief individual CBT with structured self-help materials, brief CBT by telephone, or group CBT. For moderate functional impairment it recommends a choice of an

SSRI or more intensive CBT including exposure and response prevention, of more than ten therapist hours; for severe impairment, the two combined. The guideline also recommends that clinicians routinely consider OCD in people at higher risk, such as those with depression, anxiety, substance misuse or an eating disorder, with a short set of direct screening questions that the assessment chapter of this guide reproduces.

The programme's description reads that guidance into its own design. Most adults who recognise the problem and seek help have moderate or severe OCD, for whom therapist-led CBT with exposure and response prevention is recommended, and the programme exists to help them reach it and to hold steady while they wait.