

Marcia had suffered from OCD since the age of 11, when she'd woken up one night, panicked that she might accidentally hurt someone. She screamed for her mother, who rushed into her room, stroked her hair, and told her to "think happy thoughts," while reassuring her that she was a kind, gentle girl, who'd never harm anyone. But Marcia's fears continued to spin round and round in her head.

BY MARTIN SEIF
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UPSIDE-DOWN Psychotherapy

Breaking the Rules with Our OCD Clients

Twenty years later, Marcia came to me (Martin) for help, plagued by fears of accidentally mixing cleaning fluid into her 3-year-old son's oatmeal. "There's one of those nagging thoughts again," I replied. "They can certainly be loud." I didn't point out that such a mix-up was absurdly unlikely, nor did I explore the feelings or historical meaning underlying her distress. I wasn't interested in whether she was angry with her son, nor was I concerned about how bizarre her thinking was. My attitude was relaxed and matter-of-fact, in the vein of *yeah, it sounds annoying. Now what?*

You might wonder what happened to the elements of empathy, reassurance, emotional holding, exploration, rational disputation, and anxiety-management techniques—all standard ingredients of what most clinicians

consider good psychotherapy. Clearly, Marcia was a client in distress. So shouldn't I have offered emotional support and help in understanding the meaning of her problem so she could better cope with it? Well, when it comes to OCD, we've learned that these elements of treatment aren't especially useful, and they often make things worse.

Indeed, over the last 20 years, OCD specialists have come to understand the insidious psychological processes that drive this condition and have developed variations of cognitive behavioral therapy (CBT) to treat it. We call this upside-down therapy, because it's such a departure from therapeutic staples. In fact, we've discovered that it can be helpful not only with so-called typical OCD, which features repetitive hand-washing, checking, or other behavioral compulsions, but also with a subtle form of OCD, which involves only mental compulsions. This form can look like generalized anxiety disorder, depression, agoraphobia, or even PTSD. It can masquerade as extreme trouble over making decisions, constant doubts about relationships, an inability to deal with uncertainty, or being a "control freak" about health or safety or moral questions. Our upside-down approach also helps us work with clients who suffer from intrusive thoughts that feel like impulses to do awful things. Horrified and ashamed, these individuals often

keep these thoughts under wraps, suffering for decades without getting effective help.

OCD: THE EVOLUTION OF UNDERSTANDING

Before 1980, there was no agreed-upon best method to treat people with OCD. It was considered a rare condition, largely unresponsive to traditional psychodynamic approaches. By the early '80s, however, it was being seen as far more common than formerly thought. Regardless of what may have triggered it, treatment needed to bypass psychodynamic therapy and its search for underlying causes, and focus instead on helping clients overcome their painful, often crippling symptoms.

Around this time, second-wave CBT approaches were coming of age, supplanting the first-wave models of Joseph Wolpe and

B. F. Skinner, which relied on behavioral conditioning. Based on the work of Aaron Beck, Albert Ellis, and their colleagues, the thrust of second-wave CBT was to correct thinking errors (such as catastrophizing and all-or-nothing thinking), expose clients to anxiety-raising situations, and teach anxiety-management techniques (such as rational disputation or reassuring self-talk) to promote change. These approaches were highly successful with phobias and panic, but those of us who were treating OCD found that clients were still getting caught up in repetitive arguments, “yes, but” responses, and intractable symptoms. We could reduce anxiety temporarily via rational responses, reassuring self-talk, and relaxation, but these methods rarely provided lasting change. Something else was needed.

That something else became a specific kind of CBT, called exposure and response prevention (ERP), developed and empirically validated in the 1980s by cognitive behavioral researcher Edna Foa and colleagues. It was based on a simple fact: compulsions maintain obsessions. Therefore, we need to *expose* clients to whatever triggers their obsessions and then *prevent* the compulsions. For example, if a person were obsessed with dirt and contamination, he’d be guided to touch something dirty. That would trigger the fearful obsession “What if I’m contaminated?” At that point, the therapist would instruct the client to refrain from performing his hand-washing compulsion. By tolerating anxiety without avoiding it, the fear of contamination would gradually diminish, and with it, the compulsion to hand-wash. ERP was a huge leap forward in providing therapeutic benefits to the majority of clients plagued with behavioral compulsions. It often resulted in dramatic improvements in the quality of life for those who hadn’t responded to psychodynamic, supportive, and all other talk therapies, as well as previous forms of CBT.

Yet as OCD specialists continued to work with patients via the ERP model, we began to notice something important: the key characteristic of a compulsion wasn’t an observable behavior, but its ability to provide relief from distress. In other words, compulsions could merely be thoughts. Just as cleaning might provide temporary relief for someone obsessed with dirt and contami-

relief! Unfortunately, this woman began to constantly repeat *Palmolive* in her mind and had trouble paying attention to anything else.

As we worked with OCD clients who suffered from mental compulsions only, it became clear to us that standard ERP wasn’t going to work. After all, ERP works by triggering the obsessive thought and then holding back the compulsive behavior. But when compulsions are *thoughts*, how do you tell someone not to have a thought? It’s much easier to lock the bathroom door so your client can’t wash her hands than to tell her “don’t think *Palmolive*.” We were continuing to fail our OCD clients.

DOES CONTENT MATTER?

Any therapist who specializes in OCD has watched people wrestle with strange mental obsessions, such as being afraid of stepping on chicken feces and starting an epidemic, or accidentally locking a toddler in the refrigerator. We’ve seen a gentle, young woman terrified that she might have abused a child while in the grocery store, and a refined, insightful man nearly immobilized by his fear of dropping his heart medicine on the floor where his dog might eat it and die. Such individuals come into therapy because they’re helpless to quiet their inner Cassandras.

For a long time, we continued to believe that these bizarre and disabling thoughts, with their fascinating details, must point to something important that needed to be addressed. I (Martin) remember seeing a young woman who feared that she’d accidentally strangle her baby girl. She acknowledged a troubled marriage and said she’d almost certainly divorce if not for the child. I also saw a married man who had an irresistible impulse to look at male genitals; he started an affair with a female coworker, partly to convince himself that he was straight. In the first case, I wondered whether the young mother’s repressed anger was expressing itself in these

“ Recognizing that struggling against the content of obsessions is precisely what fuels OCD led us to the startling conclusion that much of what therapists usually do actually makes the condition worse.”

nation, just *thinking about* cleaning provided similar relief. So perhaps it was the anxiety-lowering function of the compulsion that mattered most.

In fact, I (Sally) remember the moment I made this shift in my own understanding of OCD. Another therapist had presented a case in which a client had taught herself to think the word *Palmolive* to circumvent the need to wash her hands. I thought, *What a creative solution, to marshal a simple thought that produced*

the second, I speculated that there was a sexual orientation issue at hand. However, our exploration of meaning with our clients, aimed at gaining liberating insight into their fears, never seemed to help.

To add to our bewilderment, we discovered that our clients' distress levels were often independent of the imagined consequences of their fearful scenarios. It's not a great stretch to understand why a person might react with horror to the thought of inadvertently poisoning his or her spouse. But why does another person get equally concerned about possibly leaving a spoon in the dishwasher? What would be the harm?

Then there was the challenge of dealing with shifting obsessions. I (Sally) once worked with a middle-aged woman whose worries morphed almost weekly. In one session, she'd be convinced she had multiple sclerosis. The following week, she couldn't stop worrying that she might have asbestos in her house. The week after that, she'd be preoccupied with new "research" suggesting that cell phones cause brain tumors. As we addressed each concern in turn, I felt as though I were playing some version of Whack-A-Mole. The problem was the way she was responding to her worries, rather than the content of each worry. The actual content of our clients' obsessions and worries were irrelevant. We were barking up the wrong therapeutic tree.

GETTING IT RIGHT

By the turn of the 21st century, we understood that we needed to adopt a form of ERP that encompassed two additional realities. First, compulsions can be mental as well as behavioral. Second, it's not the content of obsessions or compulsions that's relevant, but rather how clients relate to them. We didn't come to these conclusions by ourselves. The evolving approaches of third-wave CBT (acceptance and commitment therapy, mindfulness-based cognitive ther-

grated the findings of cognitive psychology research with Eastern meditative practices, looking at the client's relationship to his or her thoughts, not the content. Suffering was caused by one's reactions to one's thoughts, not the thoughts themselves.

We further realized that the psychological research of Daniel Wegner, who'd studied paradoxical effort (the harder you try *not* to think something, the more you do), fit with the experience of people with OCD. The effort to vanquish unwanted thoughts only made them stronger. In addition, neurobiological research by Joseph LeDoux and others was giving us a better understanding of the neurocircuitry of the fear response. Evidence from PET scan studies in 1996 clearly showed that new pathways in the brain could be created by purely psychological interventions in OCD.

Meanwhile, new treatment research piqued our interest. Early outcome studies were validating acceptance-based approaches for panic disorder, depression, phobias, and social anxiety. The most successful interventions were those delivered in the context of an attitude of acceptance—a nonjudgmental, nonurgent awareness of the contents of the mind—combined with an active willingness to experience the feelings and sensations that accompanied the thoughts. Could this approach work for OCD too? To find out, some therapists in the field took another step forward, and by 2005, the ERP treatment process for OCD was modified to encompass an attitude of acceptance, freedom from entanglement and struggle, and a focus on metacognitive processes, rather than the content of a person's thoughts.

GUARDING AGAINST CO-COMPULSING

We came to another realization too, one equally vital to providing effective OCD treatment. The recognition that content doesn't matter, and that struggling against the

led us to the startling conclusion that much of what we therapists do for OCD sufferers actually worsens the problem. Providing empathic reassurance, rational disputation, and coping skills to manage anxiety only serves to refuel the obsession by giving clients the message that their obsession is important and intolerable, and must be fixed. We call this circular process co-compulsing.

Providing empathy and reassurance comes naturally to therapists. It's tempting to tell a client who's obsessed about a mistake he's made that others would forgive him, or to remind him compassionately that we're all human. When a client worries constantly that his wife's upcoming surgery will kill her, it seems supportive and helpful to say, "That doctor's highly skilled and has an excellent success rate." We can easily miss that we're caught up in a never-ending cycle with the client. As we dignify unanswerable questions and attempt to provide certainty or empty reassurance, we drive the client to create ever more elaborate cognitive compulsions.

Co-compulsing can initially seem effective. For example, a client of mine (Martin) blurted, "I know this sounds crazy, but I've become terrified that my friend Judy will be hurt if I don't mentally recite the William Carlos Williams poem 'The Red Wheelbarrow' every time I have the thought of her sitting at her computer."

If I replied using traditional anxiety-management tools, I might say, "Doesn't harming Judy seem incredibly unlikely, Sharon? When was the last time you hurt someone with your thoughts?" And she might feel temporarily calmer. "Of course," Sharon might say. "That is pretty outlandish." But the act of trying to argue with the anxiety-provoking thought gives it *gravitas*—if I have to vanquish this thought, it must be a big deal—allowing it to rush back as strongly as ever. This is true whether the obsession seems consistent with a person's values, such as "Will my children be happy?" or abhorrent,

such as “What if I killed someone while driving and didn’t notice?”

Are there times when discussion of an issue is helpful? Of course! If a discussion leads to a decision or action plan—and is then put to rest—it’s not an obsession. For example, if a client is worried that his car’s transmission is dying but he can’t afford a new car, a conversation about resources and budgeting can result in an action plan that slows down or ends the anxiety. But when discussions of a client’s worries go round and round, session after session, the content of the worry is likely irrelevant, and it can be tricky for a therapist to catch. Here’s how Sally got caught in the web of co-compulsing.

LOSING MY RELIGION: A CRISIS OF DOUBT

Daniel was a lanky, sandy-haired man in his 40’s who’d never been in therapy before. In our first meeting, he stated clearly what he wanted to work on. “I don’t know how to deal with religion with my children,” he began. “I’m tied up in knots over the responsibility for their souls.” My initial diagnosis was adjustment disorder with anxious mood.

Raised by strict fundamentalist parents, Daniel was currently interviewing pastors at local churches in hopes of finding one with acceptable teachings, so he could send his two children there for Sunday school. His wife didn’t much care which church he chose. “But it’s a huge problem for me,” he said. “How can I guide my children if I’m not sure what I believe?”

I talked with Daniel about how religious beliefs and spiritual values often fluctuate over a lifetime, and how having kids often prompts more attention to these issues. “You know,” I said, “trying to get your own beliefs completely sorted out before tending to those of your children might be unnecessary.”

Daniel nodded, adding that his wife was becoming increasingly annoyed with the amount of time and effort he was spending on this

issue. *Aha*, I thought, *perfectionism*. That meant that Daniel needed to become more comfortable with limited aims and imperfect solutions. So I proposed that we set realistic goals, emphasizing that there was no flawless answer to complicated questions and that compromises were okay.

This approach seemed to relieve some of Daniel’s distress. Together, we decided to concentrate on finding a “good-enough” Sunday school, deciding whether to tell his religious parents about his uncertainties as they were sending unwelcome Bible storybooks to his kids, and exploring his own beliefs about who goes to heaven. He left the office much calmer, and I felt good about the session.

But the following week, Daniel came in looking almost apologetic. “I’m feeling worse, not better,” he said. “I can’t seem to make any progress with this.” He was interviewing additional pastors.

“Daniel,” I said, “something is surely in your way, because I can see how hard you’re trying.” Since his goals had seemed so reasonable, we began to explore what feelings or issues might be preventing him from moving forward, what the resistance might be. I thought that loyalty to his parents might be at the heart of things, since he’d told me earlier that when he was growing up, his bedtime ritual involved reciting prayers with his mother, over and over, until she deemed them truly heartfelt. “I’m wondering whether your religious beliefs and feeling loved by your mom are all wrapped up together for you,” I mused out loud. “Maybe a merely ‘good-enough’ church feels like an act of disloyalty.”

Nodding, Daniel responded, “Yeah, that makes sense.” He left the office saying, “I think we’re doing good work.” I thought so, too.

But several sessions later, Daniel had made no headway in choosing a church or clarifying his own beliefs. Plus, he was becoming increasingly agitated. “It feels like I’m thinking about it even more than before,”

he said. “Even at work, I’m on the internet looking for more churches. I mean, what if my kids *do* suffer eternally and it’s because I screwed up? He twisted his hands in his lap “I can’t stand this.”

Now I was worried. Daniel and I were clearly connecting well. He was highly motivated to change. Yet he seemed stuck in place, and maybe even losing ground. Had I been missing something crucial? I knew that if Daniel didn’t develop ways to cope soon, he was going to give up on therapy.

So I decided to give traditional CBT behavioral contracting a try, to which Daniel readily agreed. His behavioral contract specified (1) spend no more than one hour per evening searching for a church; (2) tell your children “some people believe this, some people believe that” to any question you don’t know the answer to; (3) don’t upset your parents by telling them what’s going on; and (4) try to resurrect your relatively relaxed way of relating to religious questions that preceded the current crisis.

The strategy failed. Daniel kept uncovering more and more layers of inconsistencies in both what he’d been taught and what he thought he’d believed before his crisis. He’d bought several books about religion but reported, “I’m too panicked to read them.” Struggling to contain my own frustration and self-doubt, we did a little work on how to relax his body so he could read. Soon afterward, his wife suggested that he terminate therapy, claiming that it wasn’t helping—that, in fact, it was making things worse.

She was correct. After months of therapeutic conversations, Daniel was suffering a cascading series of concerns, doubts, and anxieties that continued to pop up regularly. He and I were spinning around on a merry-go-round of problem-solving strategies, coping mechanisms, and insight-chasing, all of which were backfiring.

Why? Because all this time, I’d been

unwittingly co-compulsing. Daniel would come in with an upsetting, obsessive thought, such as, "What if I'm being punished for straying from the religion of my youth?" I'd get involved in the content of his worry and jump in with solutions. These provided temporary relief, but in the end reinforced and drove the next cycle of obsession and anxiety. In fact, my therapeutic recommendations became new compulsions.

Here's what finally enabled me to grasp the problem. I was watching *The Aviator*, a film about Howard Hughes, who suffered from severe OCD. One flashback scene showed Hughes as a child being scrubbed repeatedly and roughly in the bathtub. Some people had interpreted this scene as indicating the "cause" of his OCD as childhood abuse, but because I knew that OCD is highly heritable, I understood immediately that this was Hughes's mother's own untreated OCD.

I flashed on Daniel telling me about his own mother's bedtime prayer rituals and realized that my client had OCD. He was wracked by intrusive doubts. His search for certainty was hopeless. He had a subtle form of OCD, the kind characterized by purely mental compulsions. Because his obsessions made sense to him and because his compulsions included few observable behaviors, I'd missed the OCD cycle that maintained and escalated his distress. There'd be no more efforts to elicit aha moments, no more can-do strategies. Daniel needed an upside-down form of therapy.

LETTING BE, LIGHTENING UP

Upside-down therapy is our integration of traditional evidence-based ERP, acceptance and commitment therapy, metacognitive therapy, and mindfulness-based cognitive therapy. It's an approach for avoiding the trap of co-compulsing and successfully helping people with subtle OCD.

Upside-down therapy helps clients tolerate anxiety-arousing thoughts



“We were spinning on a merry-go-round of problem-solving strategies, all of which created the illusion of helping but were backfiring big time.”

(obsessions) and learn to become less entangled with them. It doesn't delve into meaning, rational disputation, empathic reassurance, or exploration of alternative solutions. It's about helping clients face their distressingly sticky thoughts and refrain from efforts to fix them. It focuses on acceptance without a struggle. It changes clients' relationship to their thoughts. Obsessions become less powerful, and gradually fade into the background.

The first task, of course, is to make the diagnosis, so often missed in clients who seem obsessional but whose compulsions are cognitive only with content that isn't necessarily bizarre. If what looks like an issue returns repeatedly, often in morphing forms, and attempts to explore, reframe, dispute, resolve, or cope with the issue don't help, then subtle OCD may well be present. It's time to take the following steps.

STEP 1: Identify the obsessions and the compulsions. Obsessive thoughts and images raise anxiety, while compulsive thoughts and actions are attempts to lower it. In Daniel's case, his repetitive, unanswerable what-ifs were clearly obsessions. *What if I can't figure out what I truly believe? What if my kids' souls are jeopardized by my doubts and actions?*

What were Daniel's compulsions? They were all the ways he tried to answer these unanswerable questions to relieve the anxiety triggered by his obsession. His compulsions included further exploration, prayer, research on religion, seeking reassurance from his pastors and me, reframing and refuting, and planning and thinking. He was searching for the "just right" answer that would never come.

STEP 2: Educate the client. I said to Daniel, "I'm sorry. I believe I missed the boat here. Your lack of progress isn't your fault. I now understand that you have a form of subtle OCD. Your obsessions and compulsions aren't obvious, like a germ phobia or constantly checking that the stove is turned off. But they're still there." I further explained that there was an inherited factor. "People with OCD have a genetic predisposition for their minds to become sticky under stress and fatigue," I said. "In your case, a biologically sticky mind and your love for your children have combined to create the particular recurring thoughts and fears that are making you so miserable. Here's the single most important thing you need to know about the OCD cycle

and how to liberate yourself from it. Your thoughts get stuck by the force with which you fight them. The solution to overthinking isn't more thinking, but learning a different way to relate to your thoughts: Just imagine you're driving your kids on a long trip while they whine and argue in the back seat. They're safely strapped in, but very annoying. You have to let their complaints go in one ear and out the other because you need to keep your attention on the road. It may be impossible to tune them out totally, but quite possible to let them gripe and not get involved. And from now on, we're going to treat your worried thoughts as though they're squabbling kids in the back seat—annoying but not dangerous, and best left alone until they fall asleep on their own.”

It didn't matter that the worries seemed meaningful to Daniel. What mattered was that his agony was being maintained by his frantic attempts to make the worries go away. That had to stop.

STEP 3: Use modified ERP. Daniel and I agreed on a three-part homework program. First, every time he had an obsessional thought, such as, *I have to decide now or my kids' souls are in jeopardy* or *What if my suffering is punishment for my doubts?* he'd rephrase it preceded by the words *I'm having the thought that*. This allowed him to label his thought as an obsession, not a genuine issue.

Second, he was to make a mark on a sheet of paper to tally up the number (not the content) of obsessive thoughts he had each day, and he wasn't permitted to try to answer any what-if questions that came up.

Third, he got an extra mark for recognizing any new obsessional intrusion. He wasn't to try to make the thoughts go away or engage with them in any way, but simply to notice and count them. “These marks don't get you anything except a different kind of awareness,” I said. “This will help you bypass what the thoughts seems to be *about* and make you less

reactive to them. Just count, don't get all involved.” This is disentanglement.

STEP 4: Be playful. I also introduced exposure treatment with an element of silliness. We practiced singing the worst of his worries—“My kids are going to hell”—to the tune of Happy Birthday. We tossed a ball back and forth across the office while coming up with “bad thoughts,” such

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as *I'm responsible for the eternal torture of my kids* or *I'll lose my wife over this*. We were, in effect, giving his internal bully a Bronx cheer.

Within weeks, Daniel stopped thinking he had an urgent need to solve the issue of his kids' religion. On the occasions when intrusive thoughts and doubts popped up, he was able to treat them like meaningless hiccups of the mind and let time pass until they subsided on their own. He knew they'd continue to

show up from time to time, but no longer dreaded them.

We had two sessions with his wife one to explain subtle OCD and one to help her recognize when she was participating in co-compulsing and how to affectionately withdraw from the content of Daniel's concern. They sent their kids to a “good enough” Sunday school at a church where several of their friends went. They agreed that they'd gently and kindly decline conversations about religion with his parents. And they began doing things just for fun, like going to jazz clubs and even taking an improv class together. He was beginning to live again.

Daniel knew he'd always have a somewhat sticky mind and that his OCD might well find other ways and topics to launch an attack. In fact, he'd recognized in retrospect an episode of OCD during college when he'd been convinced he had meningitis. But he also knew he was prepared with the right attitude and strategy toward sticky thoughts: don't get entangled, don't fight them, don't be afraid of them. Daniel responded quickly and successfully to upside-down therapy, once we got the diagnosis right. But Martin's case involving his client Marcia was more challenging to resolve.

“I'M AFRAID I'LL HURT HIM”

Let's return to the story of Marcia, from the beginning of this article, who was terrified of accidentally putting cleaning fluid in her son's oatmeal. People with obsessive thoughts about harming others are desperate for reassurance that they won't actually do what they repetitively think about. Here's how I avoided co-compulsing while helping Marcia cope with the intruders in her mind.

At our first meeting, I took a detailed history of Marcia's symptoms and then told her, “You have a form of unwanted intrusive thoughts called OCD. I know these thoughts are scary and embarrassing, and you fear that you might act on them. So you've

been fighting them, with valor, for a long time. I know you've suffered a great deal. But the good news is that there's treatment that can help you find your way back to a normal life."

Marcia looked skeptical. "But I worry that maybe I unconsciously want to murder my son," she said. "It seems impossible because I love him so much. But I keep thinking about it anyway."

"Actually," I said, "only people who abhor violence get such stuck thoughts. Your fears have nothing to do with any anger that you might—or might not—have for your son. You're in no danger of doing what you fear. But I understand that you don't trust that as yet." When Marcia nodded, I made a proposal. "These thoughts are intrusive and offensive, and I'd like you to think of them as hecklers. Don't dignify them with a response."

She raised an eyebrow. "Yeah? And how am I supposed to do that?"

"Well, imagine that you're walking down the street," I said. "Some guy walks toward you and makes a disgusting comment as you pass by. What's the best thing for you to do?"

Without hesitation, Marcia said,

"Ignore him. Keep on walking. Don't even look at him."

"Yes," I said. "He might frighten you, and there might be a part of you that wants to answer him, but you know that ignoring him gives you the best chance of keeping him from bothering you anymore. Any answer will make him likelier to continue. And that's just how I'd like you to react to these thoughts. They may frighten you, but don't answer them. Go on with what you're doing. We'll go over more specifics on how to do that, but this is the general approach I'd like you to take."

Now Marcia looked agitated. "But let's say that guy has a knife," she said. "What if he really hurts me?"

"I can't guarantee your safety," I said calmly. "But I can help you make the distinction between reasonable risks and unreasonable ones, and I can help you deal with uncertainty."

Marcia bit her lip. "So you aren't certain that I won't hurt my son?"

"What I do know is that certainty is a feeling, not a fact," I responded. "And your task is to learn how to live with uncertainty. You do it in other aspects of your life—asking your boss for a raise, investing

your money, deciding to drive your car. You take reasonable risks everywhere else, but in this particular case, you're demanding certainty." I explained to Marcia that her desire for constant reassurance and her ongoing efforts to block her fearful thoughts were actually energizing her fears and making her fearful thoughts even louder and stickier. "You're a reassurance junkie, and we need to detoxify you from that addictive need," I continued. "So for the next week, I want you to record every time you ask someone for reassurance that you won't act on your obsessive thought."

At our next meeting, Marcia began talking even before she sat down. "I can't believe how often I ask people for reassurance," she said. "Dozens of times a day!"

Now that I'd gotten Marcia's baseline level of reassurance requests, I asked her to limit them to just 10 each day. Then to five each day. After that, I gave her a reassurance coupon book. It contained 10 coupons that she could use anytime, but she couldn't get a refill until we met a week later. This simple reduction of

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Key Elements of Subtle OCD

STICKY MIND is the biological element. It's the experience of reverberating and intrusive thoughts that get stuck, the inability to let go of thoughts, and the ongoing, painful focus on the feeling of uncertainty. People with OCD have a genetic predisposition for their minds to become sticky under physical or psychological stress, fatigue, and major developmental tasks, such as going away to college, falling in love, or dealing with a major change. Medications such as SSRIs and adjunctive atypical antipsychotics can address sticky mind with increasing effectiveness, and the search is ongoing for even better psy-

chopharmacological interventions. Meds are often a part of treatment and maintenance of recovery, particularly if stickiness is so intractable that therapy alone is insufficient. Exercise and yoga can also affect this predisposition, as can an ongoing practice of mindfulness meditation.

But addressing sticky mind alone is often not enough to provide real relief from OCD unless two other elements are addressed. **ENTANGLEMENT** refers to one's relationship with one's own mind. People vulnerable to entanglement tend to appraise thoughts, images, and sensations incorrectly, fashioning mean-

ings and warning signals out of passing mental detritus. These individuals tend to be engulfed by their fears, rather than being able to observe them dispassionately. They're likely to be afraid, ashamed, or disgusted by their thoughts and feelings.

PARADOXICAL EFFORT refers to urgent attempts to control or change thoughts, which serve to maintain the OCD cycle. A classic, often-recounted example is the command "Don't think of a white bear." It becomes almost impossible not to think of one. The struggling *against* a thought, paradoxically, makes it stronger and more stubborn.

reassurance-seeking began to quiet the engine that drove Marcia's obsessions. She found it difficult and sometimes frightening to let go of certainty, but gradually the sticky thoughts lessened their power to upset her.

Several months later, while battling considerable job stress, Marcia told me that the fear of poisoning her son was returning with a vengeance. I replied, "There's one of those nagging thoughts again. They can certainly be loud."

"Yeah," she agreed. "But I haven't let them get to me so much this time."

"You can be very proud of that," I said. "You aren't changing your behavior in response to the bully in your head." Then I added, "But remember, those thoughts can always come back. They will come back. So you need to leave room for them. Set a place for them at the table. Fighting them only makes them stickier."

"I'm still having trouble with that," Marcia stated. "I'm just not sure what that means."

"Remember that guy who makes disgusting comments to you on the street?" I responded. "Well, he'll continue to do that, sometimes more frequently, sometimes much less. You can't pretend he's not there, but you don't have to let him bully you into crossing the street to avoid him or trying to fight back and crowd him out. Instead, allow him room to go right past you, and if he says something vile and upsetting to you, don't dignify his comments with a response."

Marcia worked hard to allow these thoughts to go unanswered, but her harming obsessions felt so real, so sticky, and so threatening, that she began to feel overwhelmed and dispirited.

After two months of this struggle, I said to her, "Marcia, you're working hard. You deserve an A-plus, but now is the right time to consider medication."

"Oh no!" she exclaimed. "That

means I'm hopeless and you've given up on me!"

"It's the opposite," I responded. "I see how hard you work, and the right medication can often make your struggle just a little bit easier. It can tip the balance in your favor."

When she agreed, I referred Marcia to a psychiatrist who is experienced and knowledgeable about OCD. She started on an SSRI, with her dosage gradually increasing over the next two months. She improved discernibly and suffered few side effects. In a session last month, she said, "Now the obsessions don't seem as real. They seem more like thoughts, not so much like impulses. I don't get quite that whoosh of terror. And after a little while, they kind of melt away."

WHAT WE'VE LEARNED

Over the past several decades, it's become clear that OCD is a complex biopsychosocial disorder, with strong genetic and learning components. It's a chronic, intermittent condition, which tends to wax and wane over a lifetime and increase during periods of stress, developmental tasks, and change. Recovery isn't merely the absence of symptoms; rather, a person has recovered when the occurrence of symptoms no longer causes distress, when a stray obsessive worry no longer compels a frantic response, when content isn't taken too seriously, and when OCD no longer functions as a bully of the mind because there's no struggle or engagement to fuel it.

People with milder cases of OCD can recover in weeks or months, with or without medication, and can be inoculated for life if they understand that thoughts might well return, but suffering need not. More severe cases of OCD may require sophisticated and complex medication management and more intense, multilayered psychological treatment. Some clients may need multigenerational family therapy or couples work. Not every individual recovers: some peo-

ple need intensive residential treatment or years of ongoing treatment. But even the most severely affected clients are helped when therapists avoid co-compulsing and teach them to accept their thoughts and shrug at them.

Many OCD sufferers don't even know they have the condition because they don't match the stereotype of the compulsive hand-washer and detail-checker. Instead, they may think of themselves as inveterate worriers or hypochondriacs or perfectionists, indecisive or stuck on some issue they can't resolve. But when they come to understand the way OCD works, and how their attempts to cope are actually maintaining their suffering, most are eager to learn how to move beyond it.

As clinicians, it can be especially gratifying to treat people with subtle forms of OCD. Many have been wildly misdiagnosed and, despite years of trying to be good therapy clients, feel as out-of-control as ever. Upside-down therapy makes sense right out of the box and can seem like a revelation for them. But the approach is no miracle cure. While some recover quickly, others require extraordinary patience, persistence, and personal discipline to make progress. Helping them means repeating, reinforcing, and creating new ways of teaching the attitudinal changes that allow them to move on with their lives.

To be sure, upside-down therapy can require clinicians to make a fundamental shift of perspective. After all, it's practically in a therapist's DNA to want to wrap our client in understanding and empathy. We connect, in part, through the process of pledging to help them comprehend and contest their demons. To some clinical traditionalists, it may seem to be ignoring or minimizing their most urgent fears and needs. But that's the last thing we're doing. We support our clients with all our hearts and profoundly sympathize with the waking nightmares they're experiencing, and we te

them so. We make sure they know that we recognize the depth of their suffering. But what we're not doing is unproductively engaging with the content of their particular obsessions—the fear of harming others, the disturbing sexual thoughts, the repetitive worries about offending friends and family. Instead, we turn the problem on its head, helping OCD sufferers stop battling their inner terrorists and develop a gentler and accepting connection with their minds. The most compassionate path is the one that leads to recovery.

As clinicians specializing in work with OCD clients, we've learned what it means to accompany people on this sometimes circuitous path. We get to see them move beyond the relentless cacophony of intrusive, troubling thoughts and the frantic attempts to change them. We help them inhabit a calmer space—one that makes room for normal pleasures and the ordinary uncertainties and reasonable risks of daily life. ■

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a name for what was plaguing me—but also a treatment.

Slowly, the pressure on my brain began to lift. For the first time in months, I could fall asleep on my own, without the aid of Ambien or a glass of wine. My obsessive thoughts began to decrease in frequency and intensity—small outbursts would dissipate rather than turn into raging duels in my brain that would last for hours. The faint slant of light from the outside was growing brighter. A sense of perspective returned. Instead of being crouched over on the stage of my life, I could now stand back in different parts of the theater to consider the different acts and passages with a different focus and broader viewpoints.

Only then, after the SSRI had had enough time to calm my thoughts, was talk therapy able to help me begin to take control of the various emotional threads of my life that had helped propel me so deep into the labyrinth of OCD. Just as one needs to reset a broken bone before physical therapy, I needed Zoloft to reset my brain before talk therapy could help me find my way out of my OCD labyrinth.

With the worst ruminative symptoms at bay, I could begin to address the dynamics in my life that had exacerbated my symptoms. What I hoped—and needed—to gain from talk therapy was the additional insight, motivation, and strategies to help me revisit old emotional issues and find new ways to change the self-defeating, self-doubting, self-critical talk that had been now loosening under the dual impact of Zoloft and my sessions with Dr. S.

Over the next weeks, she helped me distinguish between being meticulous and being obsessive. So when the editors agreed to put in an introductory clause freeing me (and the publishing company) from legal liability, I was able to recognize that although I felt vindicated, I'd gone overboard in my

obsessive worrying, to the point of being obnoxious.

Similarly, therapy helped me disentangle the real fears of HIV with the overdue need for Peter and me to talk, to touch each other, to overcome our mutual fears of contagion and instead to learn, anew, ways to be together to comfort and love each other.

As for my fractures within, I reflected that my repeated checking of facts and fears of errors or of repetitions or of clichés had begun as self-protective coping mechanisms against my critical father and my internalized self-critic. But these strategies to escape the maze of the family had ultimately only led to a different type of trap.

No, I couldn't control or prevent future tragedies through the act of ruminating about them. But how could I control my ruminations? In time, I trained myself to refrain from asking others (whether Peter or a friend) for reassurance about something I said or wrote. Engaging in meaningful distractions—playing the piano, watching a movie, becoming engrossed in a good book—also helped. But perhaps the most helpful thing was learning to label my ruminative eruptions as, well, eruptions. Zoloft allowed me that clarity—and with it, the mental strength to manage the frightful medical crisis of Peter's last illness, and the ongoing grief after his death.

LEARNING A LESSON

Over time, my weekly appointments with Dr. S. first became monthly sessions and then "well-baby visits" every few months to check on my mood as well as my medication level. Assessing the efficacy of Zoloft was also part of these sessions through the years. And during the months of my husband's last illness, and after his death, I resumed weekly visits, essential for helping sort through the many layers of grief, loss, and practical logistics confronting me.