compulsions. Continued practice and use of the tools and skills learned in CBT will help keep symptoms manageable. Successful cognitive behavioral treatment requires motivation and daily practice. Initially, it can appear quite challenging, even scary, but obtaining relief from OCD symptoms makes it worthwhile. When used together, medication and cognitive behavioral therapy complement each other. Medication can have beneficial effects on serotonin levels, while cognitive behavioral therapy helps modify behavior by teaching the person with OCD the skills to resist compulsions and obsessions. Medication can reduce anxiety levels, making it easier to implement cognitive behavioral therapy tools and techniques.

Exposure and Response Prevention

Exposure and response prevention is the principal cognitive behavioral technique for treating OCD. The purpose of ERP is to reduce the anxiety and discomfort associated with obsessions through the natural process of sensory *habituation*. Habituation, which is hardwired into the brain, is a natural process whereby the central nervous system gets used to stimuli through repeated, prolonged contact; you might even say the nervous system gets bored with these stimuli. There are endless examples of habituation at work in our daily lives. One example would be the sudden, jolting chill you feel when you dive into a pool of cold water. The sensory neurons in your skin (assigned to detect sensory information about hot and cold) send an initial barrage of temperature-related information to your brain, which interprets this to mean "Boy, this water sure is cold!" However, if you remain in the water, after a few seconds those same sensory neurons on the skin start to fatigue and the transmittal of information about hot and cold virtually stops. The chilling sensations diminish, and gradually the cold water begins to feel almost warm. Obviously, the water doesn't become warmer. Rather, your nervous system numbs out to the chilly sensations as you habituate to the cold water.

There are countless other examples. Here's one you could try right now. Take a mouthful of luscious, flavorful food in your mouth—something you really love—and hold it there for a minute without swallowing. The intense flavors eventually fade away, indicating that habituation to the sensations of flavor have occurred. Likewise, if you've ever worked with the radio blaring in the background or an airplane roaring overhead, you've probably noticed how you can be so absorbed in a task that after a while you may not even hear the continuous background noise. After prolonged, repeated contact with any physical or psychological stimulus, habituation will occur. Habituation also reliably occurs in situations that initially evoke feelings of anxiety and fear. If you stay in persistent contact with those experiences, habituation will occur, providing a natural way to overcome avoidance of anxiety-provoking situations.

EXPOSURE

You can use this process to your advantage by arranging for prolonged exposure to the real-life situations that provoke anxiety and cause you to perform rituals. This is called in vivo, or real-life, exposure. For example, a person with fears related to contamination might be asked to touch or otherwise directly contact some feared object, such as an empty garbage can, without relieving the anxiety by hand washing. Through repeated practice, the person realizes that the feared disastrous consequences don't occur, and the severe anxiety initially associated with that situation decreases.

Exposure is best done in stages, taking baby steps toward the ultimate goal of complete habituation to the feared object or situation. For example, exposure to a "contaminated" garbage can may begin with the person touching a "safe" corner with only a fingernail. Eventually, exposure progresses to touching the garbage can with a finger and waiting as long as it takes for habituation to occur. Then several fingers are used, then the front of the hand, then the back of the hand. With each step, the person confronts the fear, experiences anxiety, then experiences habituation gradually and naturally. (Note: In this book when we use the word "contaminated" in quotation marks, we mean that the person with OCD would consider the object or situation to be dirty, disgusting, dangerous, and to be avoided at all costs, while most people wouldn't consider it dangerous in any way.)

Sometimes it's either impractical or impossible to re-create the feared situation. An example is the fear of becoming sick or losing a loved one. In these cases, *imaginal exposure* is used. This involves prolonged, repeated mental visualization of the feared image or situation, again for as long as it takes for habituation to occur. In combination with in vivo exposure, imaginal exposure is also a useful technique for overcoming the fear of thoughts that so many people with OCD experience. This book offers detailed instructions on how to devise and implement both in vivo and imaginal exposure to help you break free from OCD. With patience and practice, this approach will help decrease the intensity of your obsessions.

RESPONSE PREVENTION

Think of response prevention as the act of voluntarily preventing the rituals (washing, checking, and so on) you typically perform when an obsession triggers anxiety. The purpose of response prevention is to encourage habituation to fear-provoking thoughts and situations, and to ultimately decrease the frequency of rituals. As you face feared stimuli and experience the urge to do rituals, you simultaneously refrain from ritual behaviors such as hand washing or excessive checking. At first you may simply decrease the length and frequency of a ritual as you gradually work toward totally resisting the compulsion. Ultimately, the goal of response prevention is to stop all compulsive rituals. This may sound impossible or even frightening, but with regular effort, practice, and the strong support of a coach, such as a therapist or family member, response prevention is possible—and one of the most powerful keys for breaking free of OCD.

Cognitive Restructuring

The cognitive component of cognitive behavioral therapy involves actively challenging and confronting the distorted thinking and faulty beliefs that drive and maintain obsessions and compulsions. In cognitive therapy, you are encouraged to identify faulty beliefs and replace them with more accurate and realistic appraisals. This approach is traditionally done through interactions between therapist and client in a process sometimes referred to as *cognitive restructuring*, but it's also possible to use this technique in a self-help format, as in the self-directed program in this book. Here are the key cognitive errors of people with OCD, with examples of each.

Overestimating risk, harm, and danger. Examples: "If I take even the slightest chance, something terrible is likely to happen." "The mere possibility of danger equals the probability of danger occurring."

Overcontrol and perfectionism. Example: "Whatever I do, it's intolerable unless I do it perfectly."

Catastrophizing. Examples: "An open sore on my arm means I'll definitely get AIDS if I am around someone I think has AIDS." "If I get angry with my mother, it must definitely mean I'm a violent person."

Black-and-white or all-or-nothing thinking. Examples: "If I'm not perfectly safe, then I'm in great, overwhelming danger." "If I don't do it perfectly, then I've done it horribly."

Magical thinking. Example: "If I think of a bad, horrible thought, it will certainly cause something bad or horrible to happen."

Thought-action fusion (similar to magical thinking). Example: "If I have a bad, horrible thought about harming someone, it feels just as if I've actually done it or as if it makes it more likely to happen in the future."

Overvaluing thoughts. Example: "If I think of a terrible event occurring, the likelihood that it will actually take place is very high."

Overresponsibility. Example: "I must always, at all times, guard against making a mistake that could possibly harm an innocent person, no matter how remote that possibility."

Pessimistic bias. Example: "If something bad is going to happen, it is much more likely to happen to me or to someone I love or care about than to others."

What-if thinking. *Examples: "In the future, what if I make a mistake [do it wrong, get AIDS, am responsible for causing harm to someone, and so on]?"*

Intolerance of uncertainty. Example: "I can't relax until I'm 100 percent certain of *everything and know that everything will be okay. If I'm uncertain about anything* (my future, my health, the health of loved ones), it is intolerable."

Hypermorality. Example: "I'll go to hell (or be punished severely) for even the slightest mistake, error, or transgression."

The "martyr complex." Example: "How noble and wonderful I am! I'll gladly suffer and sacrifice my life doing endless rituals (washing, counting, checking, and so on) all day long as a small price to pay to protect those I love from danger and harm. And since no one close to me has yet died or suffered great harm, I must be doing something right!"

While changes in OCD-related beliefs are vital to recovery, there is disagreement among clinicians and researchers as to how best to achieve those changes. Some controlled studies show that people improve just as much when they actively challenge their beliefs about the situations that cause them anxiety as when they engage actively in exposure and response prevention to those situations (van Oppen et al. 1995; Cottraux et al. 2001; Emmelkamp and Beens 1991). In other words, some experts that believe that direct exposure to fear provoking situations (like touching a "contaminated" toilet seat) may not be necessary. The approach taken in this book (and that taken by most expert clinicians in the field of OCD treatment), is that ERP is the best way to change OCD-related beliefs and behaviors, but that there is also an important role for actively examining and challenging the faulty beliefs that maintain symptoms (described in chapter 8), especially for people with overvalued ideas or those who find exposure too challenging. For the vast majority of people with OCD, the combination of ERP and cognitive therapy provides the optimum set of tools for fighting and breaking free from OCD.

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