Working with people with OCD during the Covid19 pandemic

Oxford Health Specialist Psychological Interventions Clinic & Oxford Cognitive Therapy Centre

This guide is aimed at therapists and therapists-in-training who have skills in CBT and have some familiarity with OCD, who are receiving suitable supervision. Each individual person with OCD will have different thoughts, beliefs and associated behaviours; the treatment suggested below should be tailored to each person's difficulties.

Key principles of and skills in CBT can be applied during the unprecedented circumstances of the Covid-19 pandemic and associated restrictions.

The social distancing restrictions and hand-washing instructions closely map on to common OCD fears; CBT focussed on contamination fears can still continue in these circumstances.

When working remotely with people with OCD via video conferencing, you can use the same treatment components in the order recommended for face-to-face treatment.

The therapeutic relationship – we are all in this together

As part of engagement with clients, and part of the process of normalising the occurrence of and reaction to intrusive thoughts, we would consider how much to disclose our own concerns, as part of the genuine, warm, collaborative relationship versus colluding with OCD and reinforcing fears. This is not a problem unique to the Covid-19 situation; often in therapy sessions we are faced with the dilemma of sharing personal experience and whether this is helpful or potentially disadvantageous. At this time of population-wide anxiety, it is likely that many therapists are also concerned about their own health / health of loved ones / health of the population, and it is likely to be helpful to reflect on this and to think about everyone is coping with this higher level of threat. There are useful media articles and posts on OCD charity websites about how everyone can benefit from general care of their mental well-being.

The therapist will need to respond to the individual client about how much to continue with 'business as usual', titrated against how much the client needs to talk about their general adjustment to the unusual circumstances. Given a limited number of sessions available to people to work on OCD, as soon as possible, active work on OCD should start / resume.

Normalising intrusive thoughts
This can take place as normal in face-to-face sessions, using guided discovery in exploratory discussion about the nature of thoughts, and relevant metaphors which help the person to understand how intrusive thoughts work. Lists of commonly occurring intrusive thoughts can be found online and shared, and used to develop a discussion about the fact that there is no difference between the intrusive thoughts experienced by the person with OCD and those who don't have OCD, and why the thoughts are become problematic (as they are perceived as important and signalling threat and responsibility). Covid-19 related cognitions could include:

Thoughts: *'That is contaminated with the virus'*
Doubts: *'Did I wash my hands?'*
Images: *Of self or others lying in hospital on a ventilator*

It is likely that most people aware of the Covid-19 virus have experienced all of these, and have been somewhat distressed or anxious for a short time. In OCD, it is the appraisal of these thoughts and associated behaviours that lead to the maintenance of this distressing problem.

Developing a 'vicious flower' formulation: identifying the threat appraisal
Intrusive thoughts / doubts / images are difficult to ignore or dismiss when they are appraised as significant, important or as signals of danger. We need to know what the occurrence or content of the thought means to the person experiencing it. OCD develops as a person believes they are responsible for preventing harm, or for making restitution if they believe they have been responsible for harm. A number of beliefs may be relevant when developing a shared understanding of how OCD is maintained:

Over-importance of thoughts
Treating thoughts such as 'this is contaminated' or 'I'm developing symptoms' or images of illness as facts and prompts to action rather than thoughts or worries that will pass.

Inflated sense of responsibility
It is important to use 'downward arrow' questions to ask about how the threat of Covid19 may be related to personal responsibility to establish the key threat appraisal e.g. *'If I don't wash my hands properly, then I will be responsible for… [transmission of Covid19 to vulnerable others? Transmission to the entire population? My own death leaving my family without a parent?]'*. Questions such as *'what is so bad about that?'* or *'what's the worst thing about that?'* will help to access beliefs about responsibility. Thought-action fusion is sometimes present within a responsibility appraisal —when someone believes that thinking something increases the likelihood of it actually happening and / or that having the thought is the moral equivalent of carrying out the thought. E.g. having a thought about a loved one dying would mean that it was going to happen, and that I am wishing death on them.

Perfectionism
The application of arbitrary high or impossible standards: '*If I don't wash my hands perfectly, I will contract the virus'* with a 'perfect' handwash concluded on the basis of a 'just right feeling' or by repeating a certain number of times that are unrelated to government guidelines.

Intolerance of uncertainty
E.g. *'I have to be absolutely certain that there is no trace of the virus on me'.* The entire population is having to deal with an increased level of uncertainty about the level of contagion, the length of the lockdown, when we can return to 'normal' and what society will look like at the end of this crisis. It is useful to discuss how this is likely to feel worse for people with OCD, but also not to make assumptions that this is the case. What we know about uncertainty is that repeated

checking, reviewing and re-doing actions makes us less certain and more anxious. So repeated monitoring of the news, repeated hand washing, etc. are not going to make anyone feel more certain of their safety. In fact, this may make everything more frightening.

Over-estimation of threat
There is a higher level of threat in the general population that most people have ever experienced. Picking up on examples of 'all or nothing thinking' e.g. *'if I touch anything I will die'* and 'jumping to conclusions' e.g. *'if I feel slightly unwell, I will die from the coronavirus'* can be used to unpack the idiosyncratic appraisal of risk.

The anxiety equation may be helpful to establish what components maintaining the high levels of anxiety. For example, perceiving a high probability of contagion and 'awfulness' of illness / death / consequences of illness / death, along with low availability of personal and national resources in the event of illness. This equation can be used in later sessions to help people to reflect on their perceived level of threat.

Identifying maintenance factors
Once the meaning attached to the intrusive thoughts has been identified, the next task is to establish what someone does once that threat appraisal is activated. These safety-seeking behaviours (SSBs), attentional biases and avoidance will all maintain the threat appraisal, perpetuating this frightening belief, and contributing to occurrence and salience of further intrusive thoughts. A useful phrase is 'the solution becomes the problem' when coming to a shared understanding of how these behaviours start off as attempts to feel better, but quickly come maintain OCD.

Maintenance process	**Examples**	**Why the solution becomes a problem**	**Examples of how to target in CBT**	**'Non-OCD' alternative** **NB when this 'non-OCD' alternative is possible - what else is also possible – link to goals.**
Hypervigilance and selective attention	To own bodily sensations e.g. being hot, coughing	The more attention you pay to e.g. a bodily sensation, the more you will notice it, and notice less the occasions when the sensation was absent	Giving examples of how attention is drawn to objects (or body parts) of salience Notice the difference between being very focused on symptoms, vs. not	Be able to disregard / tolerate changes in bodily feelings
	Increased awareness of potential Covid19 contaminants in your own home	The harder you are 'looking for trouble', the more you will believe you have found trouble, and the more frightened you will feel	Behavioural experiments with using items that 'feel' contaminated	Treat entire home as not contaminated

Avoidance	Of going out, people, touching deliveries, touching items in own home	The more you avoid, the more you will want to avoid	Elephants on the track metaphor	Touch items in your own home as you usually would or as others in your home are doing Go out - adhering to social distancing guidance
Washing	Washing in response to doubt e.g. '*are my hands really properly clean?*'	OCD feeds on doubt – the more you react to a doubt, the more doubts occur	'Who wants to be a millionaire' metaphor	Ignore the doubt Wash hands according to the Government guidelines
	Washing hands 'perfectly'	You will never reach perfection and trying to do so will result in ever increasing fear and feelings of guilt and responsibility	Behavioural experiments of 'imperfect' washing	Follow the Government guidelines Remind yourself that the guidelines state 20 seconds, not 'to the point of perfection'
	Washing hands after touching any object	The urge to wash will increase and you will never be able to satisfy yourself that it is enough	Behavioural experiment to not wash	Wash your hands according to the Government guidelines
Impossible criteria	Trying to feel completely certain that your hands are clean	Complete certainty is an impossibility You will lose confidence in your judgment	Discussion of research on memory distrust	Wash your hands according to the Government guidelines First impressions are better and more accurate Tolerate or accept the feeling of uncertainty

Seeking reassurance from others	To try to feel certain about e.g. a symptom, an aspect of the transmission of the virus	Repeated requests for reassurance increase the feeling of doubt, uncertainty and anxiety	Discussion of how to share your fears with others rather than asking for reassurance e.g. rather than saying 'can the virus be transmitted via…?', tell your friend /loved one that 'I'm feeling so anxious about everything and I need a bit of comfort / distraction / solidarity'	Not needing to ask for reassurance Agreeing with family members that they will try to provide a emotionally supportive rather than informational response
Checking	Repeated checking of the internet	Repeated searching for information increases the feeling of doubt, uncertainty and anxiety	Behavioural experiments not checking	Set specific times of day and lengths of time to look at the internet and chose the sources of information carefully
Mental rituals	Repeating phrases e.g. 'I'll escape the virus' or 'empty' ritualised praying	Increases the focus on the threat Prevents disconfirmation of belief	Behavioural experiments to practice not using the mental rituals	Allowing thoughts and images to come and go without doing anything
Thought suppression	Trying to get the image of a loved one dying out of your head	May lead to further thoughts and reinforcement of the meaning of their occurrence	Thought suppression experiments e.g. white polar bears	Allowing thoughts and images to come and go without doing anything
Rumination	Trying to work out how 'chains' of contamination might be spreading the Coronavirus around your environment	Increases doubt Lowers mood The more you focus on this, the more you will find to worry about	Discussion of tolerating or accepting some uncertainty about the nature and spread of the virus – there are teams of scientists around the world working on this –it's not up to you to work it out	Tolerating or accepting uncertainty and doubt

How to develop a useful Theory A / Theory B

Theory A / Theory B is a key therapeutic tool in CBT for OCD, health anxiety, specific phobia of vomiting (SPOV) and other anxiety disorders.

The main task in developing a theory A/B is to develop a clear, credible, and less-threatening belief that provides an alternative belief to explore through behavioural experiments and

discussion. Developing theory A/B takes at least one session and is then revised and referred to in most or all of subsequent sessions.

Theory A describes the threat appraisal identified in the vicious flower formulation e.g. for someone concerned about causing harm: '*the problem is I am a dangerous person'*. Theory B can often take the form *'My problem is that I worry that … [I am a dangerous person]'*; however, it can take on any other form and is often a lengthier statement.

For those with contamination concerns, the Covid-19 situation is likely to be feeding into theory A, as the population is being instructed that handwashing and avoidance is the way to avoid contracting a dangerous disease. The main message in CBT for OCD is that OCD is still not 'your friend' and what the OCD is telling the person about the level of threat and what they need to do is likely to be beyond the actual government guidelines and will be maintaining a higher level of anxiety than is proportional to the actual risk, and will not make the person genuinely safer than if they followed the government guidelines.

When looking at the evidence section in theory A/B, watch out for getting into 'arguments' about uncertainty e.g. we don't know whether any one person will or will not contract the virus and what their prognosis will be. Draw on similar situations such as discussion on e.g. religion – getting into religious discussions is unhelpful – it's very tempting to do so, but each argument has a counter-argument and undermines the process of developing the theory A/B. Instead, we need to accept the uncertainty, and establish that engaging in excessive safety-seeking behaviours (SSBs) and avoidance as part of OCD actually increases the sense of uncertainty. Similarly, employ caution with 'arguments' about anxiety – there is a reasonable argument that some level of anxiety and vigilance are necessary during the pandemic to ensure that people do stay at home and maintain distance from others, and to ensure that physical symptoms of illness are taken seriously. However, going beyond the government guidelines fuelled by OCD related anxiety is not helpful, as further measures may not reduce the risk of contracting Covid-19 any further, but do raise the likelihood of increasing distress and anxiety and perpetuating OCD.

<table>
<tr><td>Theory A
What my OCD and / or my feelings of anxiety are saying to me</td><td>Theory B
How the world really works
[an alternative, less threatening, credible belief]</td></tr>
<tr><td>EXAMPLES OF COVID19 RELATED BELIEFS:</td><td>EXAMPLES OF THEORY B:</td></tr>
<tr><td rowspan="3">There are germs everywhere and
I will get ill and die
I will infect others, who will die

The world will end as a consequence of Covid19 [population wipe out, civil disorder, a depression of the economy].</td><td>There are germs everywhere, but I will be ok.
Because of my OCD (my checking, avoidance …), I've messed with my confidence in how the world really works, and these SSBs make me feel anxious and alert to signs of danger, without making me actually safer.</td></tr>
<tr><td>As I have previously experienced anxiety / OCD, this is a very difficult time for me as there is a higher level of uncertainty and threat for everyone at this moment. Understandably, like everyone, I am worried about Covid19, but many of the things I've been doing when I am anxious have made me feel worse.</td></tr>
<tr><td>In these uncertain times it is not surprising that I am 'catastrophising'. However, at many times in human history terrible things have happened yet life has continued.</td></tr>
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EXAMPLES OF EVIDENCE FOR THEORY A	**EXAMPLES OF EVIDENCE FOR THEORY B**
People are getting infected and dying from the virus, including 'low risk' people.	When I feel anxious, I feel that it is more likely that something bad will happen – the feeling of anxiety is just an unpleasant feeling, it doesn't change the situation or the likelihood of me contracting the virus. When I have spent a lot of time looking at the news, or have spent a long time 'decontaminating' myself or my possessions, I have felt more anxious and upset although my risk of contracting the virus has stayed the same. OCD never actually helps me – it tricks me into gaining some short-term relief from anxiety but actually keeps me trapped in a pattern of horrible thoughts and ideas. Some people are getting infected and sadly some of them do die; however, most people are not infected, many people have mild symptoms and most people who are infected do recover. Everyone in the world is working together to find ways to stop the virus from affecting more people. There is innovation and cooperation across the globe.
EXAMPLES OF 'WHAT I NEED TO DO' AND FURTHER SECTIONS	
If theory A is true, I need to:	**If theory B is true, I need to:**
Watch the news reports as much as possible. Search the internet for stories about who is the most likely to get it. Focus on my body, particularly shortness of breath, and take my temperature frequently. Wash my hands and take precautions *in excess of the Government advice.* [any other safety-seeking behaviours, avoidance or attentional bias]	Talk to family, friends, others about a range of day to day things, not just the virus. Limit looking at the news to a few pre-set times a day Stop looking at stories on the internet that feed into my fears— this doesn't keep me safer, it makes me more distressed. Follow Government advice, not my own version of it. Acknowledge that everyone is tolerating uncertainty and distress – this might be much harder for me, but accepting uncertainty is better than being consumed by it. Be compassionate and kind to myself – this is a difficult and upsetting time for everyone— it's ok to be worried, upset or sad. When I can, contribute to the efforts to support others in my community or around the world— clap for the NHS, donate to a foodbank, ask a neighbour if they need help…
What does this say about me as a person	
I'm doomed.	I'm in an unexpectedly difficult situation and I'm doing my best.
What does this say about the future	
Bleak.	Everyone will be affected by this, whether or not they are infected, and no-one knows what will happen, but it won't go on like this forever. We are all in this together and we have an opportunity to all learn from this experience.

We can use this to acknowledge that there is a real threat (i.e., Covid-19 is contagious), but we can take a closer look at how likely it is that e.g. one will contract it, how bad it would be if one did, and the personal, community and national resources that make more manageable if this did happen

Supporting and encouraging versus reassurance
When people are working hard to overcome OCD, give them support, encouragement and praise. Their courage and strength in trying to overcome their difficulties will be impressive and uplifting. Remind them what they know about what happens to anxiety over time – it will go down. Encourage them to think about what they have done in the past to help them resist the urge to engage in SSBs and avoidance. Throughout CBT, the therapist should provide emotional support and encouragement whilst modelling tolerating uncertainty and not responding to anxiety.

Be aware of not providing reassurance— e.g. about actually being clean/that they are not contaminated or will not get ill. Also discourage any extensive fact-finding mission regarding the rates of infection or the length of time the virus lives. Remember to ask about any mental checking or interrogation of their own memory, or any other subtle SSBs that will undermine their hard-fought progress.

Whether to use statistics about Covid-19
We can make an argument that Covid-19 is 'no less of a threat than seasonal flu' based on death rates. It is important that we do not get into an exchange of statistics or opinions that are either an 'over-intellectualisation' of the problem (which takes us away from working on the emotion) or become safety-seeking behaviours *('so it's no less dangerous than flu so it's ok… or is it… I'll check the population death rates again and see how they compare'*). It is probably helpful to acknowledge the enormous amount of information available and to reflect on whether use of this information is helpful or not. If in doubt about the usefulness of information vs. it contributing to the maintenance of OCD, devise an 'on /off' behavioural experiment that tests this out e.g. look at the information vs. not - either over the course of a day as an hour on / off or as whole days on / off. The bully metaphor may be useful – asking for more and more each time, or that OCD pretends to be a friend – 'I'll protect you, I'll keep you safe' – watch out for the 'OCD lies' – more OCD will make this situation harder to endure.

With other contamination concerns such as HIV, TB – we know what measures we can take with these diseases to minimise our risk of contracting them and how to minimise the transmission risk to others – with HIV / AIDS – safer sex, not going to unlicensed tattoo shops; TB – immunisations if you live in or are visiting a higher risk area. Covid-19 has caught us out as we didn't already have a population wide means of controlling the transmission and we are unaccustomed to social distancing etc. and this draws our attention back to the risk. At a population level, this is helpful, to control the risk. As discussed above, going beyond the government guidelines fuelled by OCD related anxiety is not helpful, as further measures may not reduce the risk of contracting Covid-19 any further, but do raise the likelihood of increasing distress and anxiety and perpetuating OCD.

Planning behavioural experiments to disprove Theory A and / or build up evidence for Theory B

With some minor adjustments, therapy by remote means is similar to the face-to-face version. However, the adjustments required for behavioural experiments and exposure tasks are much greater. Some aspects of behavioural experiments are just the same as face-to-face sessions in term of considering how the person challenges their fears and builds up their belief in an alternative, less threatening explanation. These important considerations in behavioural experiments for OCD conducting in vivo or remotely are:

- Help the person to spot when they are trying to use their therapist for subtle or covert reassurance, to discuss it and find ways of not doing so e.g. independently devising behavioural experiments without telling the therapist until they have been completed.
- To identify and deal with covert / mental safety-seeking behaviours (e.g. self-reassurance, neutralising words / phrases / prayers, mental checking of actions) in place of physical safety-seeking behaviours – these covert behaviours have the same function and will undermine the planned behavioural experiment.
- To help the person not avoid the worst places for triggering intrusive thoughts.
- To help the person realise the importance of not "storing up" compulsions, rituals or neutralising, so that they are not simply feeling super anxious UNTIL they can do their rituals (which would undo any benefits of having confronted their fears).

In face-to-face and remote working, thorough discussion of these factors should be part of the preparation. In face-to-face work, acute observation of the person undertaking the BE often leads to identification of safety seeking behaviours, neutralising and/or avoidance that undermine the BE; in remote work this will be more difficult and there will need to be greater reliance on explicit discussion of these issues. Additionally, the service user can be asked to video a BE, or do it live to enable some observation.

Executing behavioural experiments and generalising the findings to other situations

Some situations may be impossible to enter in the current restrictions. In place of the actual environment / situation, service users can use imaginal exposure, or use e.g. video footage to trigger the OCD. However, for non-Covid-19 related fears, with appropriate preparation, the person can confront their fears, and modelling can take place. Online versions of behavioural experiences could include, for example, for religious concerns, undertaking a remote tour of a religious building to provoke unwanted blasphemous thoughts; for concerns regarding attraction to children, watching a children's film. Unlike face-to-face behavioural experiments, this will sometimes mean planning in the previous session so that the appropriate materials are easily to hand both for therapist and service user. In the early stages, modelling by the therapist can be included in the sessions. This may require both therapist and service user to have the same "props" with them.

As with face-to-face in vivo work, sessions are predictable and respectful, with permission being sought from the person you are working with for any fear confronting activity. This includes activity by the therapist. As with face-to-face work, watch out for any "tracking"; that is, anything the person with OCD is doing so that they can later "undo" things that they have confronted. It is important to not proceed with the behavioural experiment if "tracking" is planned; instead, collaboratively re-think the behavioural experiment as a task that the person can approach and attempt without safety-seeking behaviours before or after.

Sessions should, as with face-to-face, be long enough to complete the planned exposure and leave the person with reduced levels of anxiety (relative to the peak). Interrupting sessions whilst maintaining the activity confronting fears is also reasonable i.e. starting a long

behavioural experiment in the morning, then resuming contact later in the day to find out what happened.

Continuation of work alone including relapse prevention / management
Encourage the person you are working with to:

- Always look for opportunities to challenge the OCD
- Never do anything you are intending to undo
- If you are overwhelmed and undo things, then wait a while and redo it
- Remember that the point of all this hard work is to live a life free from OCD

Relapse prevention / management plans or 'blueprints' should include detailed thoughts on:

- What signs of trouble do I need to look out for when the restrictions are lifted? What can I do in these circumstances?
- What can I do if there is another set of restrictions or another pandemic?
