New Perspectives on Obsessive Compulsive Disorder: Busting the Common Myths

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Goals

• To tell you some things you might not know about OCD
• To update contemporary changes in clinical practice
• To leave you with sharpened diagnostic and treatment skills
• To present research-informed concepts and practices (without detailing the research findings)
• We will be taking a look at the interface between all-cognitive OCD and GAD

Myth #1

OCD is Rare.

Fact

OCD is Common

How Common is OCD?

• OCD more common than Panic Disorder—affects about 3.3 million people in the U.S.
  — 2.3% point prevalence, 4% lifetime *
• OCD often undetected; Looks like something else.
• Men and woman equally affected.
  — Boys get it earlier.
• Can start any time in life.
  — Mean onset age is 23.
• 30% of OCD depressed.**
• There is a very wide range of disability in OCD, from none to extreme. Mild cases go often go undetected

**ECA.
**NCS.
Myth #2

Obsessions are thoughts.
Compulsions are behaviors.

Fact

Both obsessions and compulsions can be thoughts.
They can also be images.

Phenomenology of Obsessions

Obsessions
- are thoughts or images which feel uncontrollable, intrusive, unacceptable, repulsive, shocking, taboo, unwelcome, unbidden, unwanted
- They are repetitive and unrelenting, although the content can change over time
- arrive with a “jolt” or “whoosh” of affect
- are ego-dystonic (not “my” thoughts)
- contain a strong urge to resist, control, ignore, suppress or dismiss

Varieties of Obsessions
- Harming (self or others)
- Contamination (danger or disgust) (germs vs icky-sticky)
- Morally repugnant
- Doubt about unanswerable questions (past, present or future reality)
- Doubt about self (intentions, motivations, feelings) eg HOCD, ROCD
- Doubt about interpersonal issues eg pathological jealousy, social hypervigilance
- Doubt about existential issues
- Incompleteness or "not just right"
- Scrupulosity (secular and religious)
- Health anxiety and hypochondriasis
- Somatosensory obsessions
- Fear of having made or might make a mistake
- Extreme quest for harm avoidance

Phenomenology of Compulsions

Compulsions
- May be observable behaviors, internal mental rituals or other forms of neutralization such as self-reassurance or avoidance planning
- They often feel driven, irresistible, and necessary
- They are repetitive and usually ordered
- They may seem rational or irrational to the sufferer
- They are intended to create safety, calm, balance, morality, health or order
- Other names for compulsion: neutralizing or safety behaviors, rituals, “coping skills”

Varieties of Compulsions
(a partial list)

Behavioral (Overt)
- Washing
- Checking
- Ordering
- Arranging
- Repeating
- Seeking reassurance
- Undoing
- Confessing

Mental (Covert)
- Counting
- Memory checking
- Self reassurance
- Mental undoing/repeating
- Arguing internally
- Ritualized prayer
- Monitoring
- “Planning”
Myth #3

Obsessions have deeper meanings that can be understood and should be explored.

Fact

Exploration of “deeper meanings” serves only to prolong and reinforce obsessions.

Obsessions “mean” that you are sensitized and have been triggered.

Fact

An Obsession is NOT Defined By Content

It is defined by how it FEELS and how it ACTS

The content itself, while not random, is meaningless

An obsession is the opposite of a wish:
It gets stuck because of energy with which it is fought

- people with harming obsessions value non-violence,
- people with blasphemy obsessions are religious,
- people who worry about blurring out something rude are polite people
- People with suicidal obsessions love life

FACT:
OCD is Overcontrol, not Undercontrol

- Distinctly different from impulse control disorders, even those that use the descriptor “compulsive” as in compulsive lying, eating, shopping, gambling, kleptomania, pyromania, pedophilia and so on....
- Intrusive thoughts can feel like impulses but they are not the same thing

Obsessions Can Be Very Bizarre

- Am I responsible for H1N1 epidemic?
- Did I poison my dog?
- Did I lock my child in my freezer?
- Is my sister looking at my genitals?
- Am I looking at my sister’s genitals?
- I am going to blurt out “you’re fat” when I see a fat person walking by.
- I keep seeing an image of me stabbing you in the eye while we are talking.
- Are we all dead?
Obsessive Content is Usually Fearful and/or Shameful/Guilty

- sex
- perversion
- violence
- suicide
- abuse
- sin
- blasphemy
- contamination
- horror/disgust
- mutilation
- disease
- dangerous mistake

Sensorimotor and “Just Right” OCD

- Obsessional fixation on body sensations can lead to compulsive checking or attempts to relieve the sensations. (Examples: chapstick addiction, repeated urination interfering with sleep, feeling one’s heartbeat, checking on salivation, swallowing, breathing, eye contact)
- Need for symmetry, order, balance, “things together”, perfection, repeating till “done”

Common Obsessive Themes

- What if I hurt (abuse, mutilate, murder, sexually assault) my baby (child, loved one, self, stranger)?
- What if I lose control and say or do something crazy (insulting, abusive, ridiculous)?
- What if suddenly do something dangerous (jump off the balcony, turn the wheel of the car, throw myself in front of the train, stab myself with a knife etc.)

More Common Obsessive Themes

- What if I get sexually aroused in the wrong situation (stare at breasts, feel turned on by my mother/father/child, have a homosexual thought)?
- What if I made a terrible mistake and don’t realize it?
- What if I get contaminated and have to wash to keep from feeling anxious and keep from spreading it to other things or people who will then get sick?

Perils of Content Interpretation

- Content interpretation of obsessions is harmful.
- It will create an increased and failing effort to control, prevent, get rid of or suppress the obsession
- This is the very fuel that maintains it.

A Better Way to View OCD

- Obsessions and compulsions are defined by their relationship to each other, not their content.
- Obsessions raise anxiety and compulsions are attempts to lower it. Compulsions function as negative reinforcers of obsessions
- Treatment is about withdrawing the fuel that maintains the symptoms
Myth #4

Most compulsions are repetitive behaviors that can be easily observed, Therefore OCD is readily diagnosed.

Fact

- Compulsions need not be behavioral or observable. They are not necessarily obvious even to the patient.
- Subtle questioning may be needed to uncover compulsions
- Compulsions can be highly idiosyncratic.
- Compulsions can seem like solutions to problems. But they only work for a while

Two Kinds of Mental Compulsions

- Some feel “driven”, ego-dystonic, and nonsensical, such as counting, repeating and ordering as well as some reassurance seeking. They are experienced as “I can’t help it”. They are not valued.
- Some are actually perceived as temporarily or potentially helpful and are invited and even valued by the patient. These include “planning”, “analyzing”, mental rehearsal, self-reassurance, mental checking, and some forms of prayer. The patient usually has no idea that these “coping skills” are precisely what is maintaining the OCD cycle.

Pathological Doubt: Not Just Worry. OCD Masquerading as Issues

- OCD can look like severe indecision and “obsessional slowness”, perfectionistic avoidance of mistakes, worries about memory and mental status, worries about interpersonal issues, and “need for control”.
- Also included is existential OCD states where doubts focus on unanswerable questions about the nature of reality, the meaning of life, how the future will be, and issues around death. This is distinctly different from concerns about values or philosophies. Fear of death obsessions can easily be misunderstood, as can suicidal OCD thoughts.

Cognitive Compulsions That Look Like Help

- I will discuss this issue with lots of people to help me decide.
- My therapist thinks it is unlikely that I will drive off the bridge so I remind myself over and over of that as I am driving.
- My rational mind tells me that it can’t be true. I need to believe my rational mind and suppress my irrational mind.
- I would never actually do that, right? RIGHT? Right?
- I can always take a Xanax if I have to
- If I just think about this a little longer, I will figure it out.
- She told me she loved me, I have to believe her.
Diagnostic Hints:

OCD often masquerades
• “Crazy” or unusual phobias are often OCD.
• AIDS, cancer, contamination and germ “phobias” are always OCD.
• “I am a worrier” or “I have trouble making decisions” or “I am overprotective or controlling” : GAD is almost never a stand-alone diagnosis: there is high comorbidity, so explore for OCD.
• Panic in response to a thought is often OCD.
• OCD in the social realm often gets labelled SAD.
• Many driving phobias are OCD, where the obsession is doing something dangerous while driving.

OCD Masquerading as “Issues” Can Derail Effective Treatment

• Obsessive intrusions can be misunderstood as urgent and meaningful messages about the nature of reality, underlying conflicts or unwanted outcroppings from the unconscious mind.
• Both obsessions and compulsions can be over-interpreted, such as
  – scrupulosity as overcompensation for some past guilty act, or
  – harming obsessions as barely controlled anger.
  – suicide obsessions as depression denied.
  – jealous checking on spouse as narcissistic or due to insecurity.
  – doubts in relationship as “red flags”
  – intrusive ego-dystonic thoughts as latent feelings (eg HOCD).

Myth #5:

People with OCD have dependent personalities and need a lot of reassurance

FACT

• Reassurance compulsions are extremely common in OCD and may masquerade as personality traits like neediness, dependency and attention-seeking.

Reassurance Compulsions

• Pester for or demanding reassurance is one way the person with OCD is trying to neutralize an obsessive symptom.
• Sharing responsibility for consequences.
• Reducing doubt attacks.
• “Urges to confess” are a particular variety of reassurance compulsions. (vs. catharsis).
• Internal, interpersonal or internet checking may co-occur.
• Reassurance “junkies” will not be helped by more reassurance.

Nature of OCD Discomfort

PURE GUILT

PURE PANIC

UNSPECIFIED DISCOMFORT
Nature of OCD Discomfort
What Patients Think Might Happen if Obsessions Came True

PURE GUILT
- I will displease God.
- I will run over someone.
- I might poison my children.
- I will get AIDS.
- I will kill myself.

PURE PANIC
- I will feel moral pain.
- I will kill my children.
- I will feel dirty.

UNSPECIFIED DISCOMFORT
- I will feel uncomfortable.
- I will lose control.
- I will think of dirty things.

OCD That Looks Like Agoraphobia

Complaint: “I’m afraid to go to the park. I might freak.”

Obsession: What if I rip off my clothes?

Compulsion: “People don’t do that.” Rehearse what to tell people. Look for “kindly” people to help. Search for cabs.

OCD That Looks Like Specific Phobia

Complaint: Afraid of dogs

Obsession: What if the dog is rabid and bit/scratched me?

Compulsion: Check body for marks, ask if dog got shots...

Ups and Downs of OCD
OCD as Agoraphobia

- Obsession: What if I rip off my clothes?
- Compulsion: People don’t do that. Rehearse what to tell people. Look for “kindly” people to help. Search for cabs.

Ups and Downs of OCD: OCD as Specific Phobia

- Obsession: What if the dog is rabid and bit/scratched me?
- Compulsion: Check body for marks, ask if dog got shots...
OCD that looks like Social Anxiety

- Obsession: What if I offended her during that conversation?
- Compulsion: When I check back over the whole conversation, I can’t see any change in her facial expression, so probably it is ok.
- Obsession: But she is very polite, she would not show how she felt or say anything
- Compulsion: Well I could ask her in an indirect way if everything is ok.
- Obsession: Well she might think I was being neurotic.
- Compulsion: Well ok, then just send her a breezy text message and see if she responds.
- Obsession: But how will I know for sure what it would mean?

OCD that looks like Panic Disorder

- Obsession: She had better not invite herself and her kids over, I will have a panic attack. I did the last time.
- Compulsion: Well maybe as long as I am not alone with the kids it will be okay.
- Obsession: But if I get one of those thoughts I could panic and upset the kids.
- Compulsion: I could take a xanax before they come.
- Obsession: I know I won’t pass out or go crazy, I just can’t stand having those awful thoughts.

OCD that looks like Depression

**Obsession:**
What if I lost the girl of my dreams? I’ll never find love. I’ll never be happy. I am a failure.

**Compulsion:**
She said she loved me, she can’t have changed her feelings so quickly, maybe I can win her back.

OCD can look psychotic

- Obsessive intrusive thought: “What if all this is not real?” (jolt)
- Compulsive reassurance: “Don’t be silly. That is ridiculous”
- Obsession: “But how can I know for sure?”
- Compulsive attempt: “Just distract yourself, this line of thought is upsetting”
- Obsession: “But the thought keeps coming back”.
- Compulsive attempt: “Well try harder to think about something else.”
- Obsession: “What is wrong with me? Why am I doubting reality? Is this how going crazy starts?”
- Compulsive attempt: “Don’t tell anyone about how obsessed you are, they will indeed think you are crazy”
- Obsession: “OMG I am having crazy thoughts that wont go away”

Ups and Downs of OCD

**OCD As Depression**

**She said she loved me**

Maybe I can get her back

I’ll go to Chicago and get her

I’ll never be happy again

I lost the love of my life

My life is ruined

I can’t go on

GAD can act as OCD-lite:

**Ego-syntonic content**

- Obsession: What if my child is in a school bus accident?
- Compulsion: Well, they are rare, the drivers are screened, the trip is short
- Obsession: Yes but they don’t use seatbelts
- Compulsion: I can drive her myself.
- Obsession: But she will miss out socially and feel different.
- Compulsion: Maybe I can organize a car pool.
- Obsession: But are the other parents good drivers? How could I know?
Ups and Downs of GAD

Treatment of Obsessive Compulsive Disorder

KNOCK 12 TIMES BEFORE ENTERING
OBSESSIVE
COMPULSIVE
CLINIC

Myth#6

OCD is hard to treat

FACT

- Effective treatments are available.
- Effective training for therapists is available.
- Good self-help books are available.
- Most patients do not need intensive treatment programs, although they are available too.

Principles of Treatment

- Effective treatment of anxiety disorders will focus not on what caused the disorder but on what maintains it. Insight alone will not interrupt the factors which exacerbate and maintain the symptoms.
- Neither traditional CBT techniques nor coping skills for managing stress treat anxiety disorders to recovery. What must change is the patient’s relationship with his symptoms.
How to Proceed

• Treat what maintains the symptoms, not what originally caused or provoked them
• Find and label the Os and Cs before you proceed.
• Make sure the patient (and his family) understand the rationale for what you are doing

What Maintains Symptoms

• Stickiness of the mind
• Entanglement
• Paradoxical Effort
• Avoidance

What Doesn’t Work

• Relaxation Training
• Exerting More Will Power
• Coping Skills for Stress Reduction
• Thought Suppression and Thought Stopping
• Distraction and Imagery Techniques
• Analyzing the Meaning of the Obsession
• Logical Refutation of Facts and Probabilities
• Compassionate repeated reassurance
• Long term insight-oriented psychotherapy

Cognitive Behavioral Treatment for OCD

Exposure and Response Prevention (ERP)
The Gold Standard

Essential Elements of CBT of OCD

• Psycho-education and hope instillation: THE GOOD NEWS IS YOU HAVE OCD
• Present treatment rationale and why both behavioral and cognitive response prevention can work instead of whatever they have been doing
• Include family and significant people as needed
• Consider medication
• Explore cognitive distortions
• Implement ERP or modification
• Relapse prevention and other psychotherapies

Psycho-Education

• Personal and family history: take a second look
• Behavioral Analysis: Label the O’s and C’s
• Reframe the experience
• Acceptable Reassurance: You have OCD, you are not crazy, this is common and treatable.
• Role of Avoidance and Anticipatory Anxiety
• Readings and videos
Exposure Plus Response Prevention

- Engage in the Obsession (i.e. raise anxiety) but refrain from performing the Compulsion
- Successful ERP Requires:
  - Realistic tasks.
  - Manageable steps.
  - Systematic work.
  - Consistency.

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Exposure Plus Response Prevention: (Standard Model)

- Develop hierarchy based on subjective discomfort of items
- Deliberately evoke anxiety-producing thought or image
- Prevent any kind of neutralization (compulsions)*
- Let time pass (let habituation occur)
- Repeat until much easier
- Move up the hierarchy to next step

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ERP with Contemporary Modifications

- Hierarchy not necessary. Choose exposures based on willingness and variability
- Decreasing anxiety within the exposure session is not necessary. (Inhibitory learning occurs)
- Generalization occurs faster with varied rather than hierarchical exposure protocol
- If the obsession no longer evokes fear-guilt-anxiety-distress-concern, the urge to compulse leaves. Treating anxiety sensitivity is the key to generalization and relapse prevention

Some ERP Principles

- Never distract during exposure. Look for subtle avoidance behaviors. (There are many) Arouse anxiety.
- Praise for courage is essential.
- Have compassion for the patient’s suffering but do not waver from the basic message that discomfort and distress are not danger.
- Work at a level which is a “stretch” but not overwhelming. Therapist can model.
- No surprises or tricks—try to always tell the truth.

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Exposure and Response Prevention: Examples

- In vivo ERP:
  - Touch the dirty thing, don’t wash, touch someone else
  - Deliberately evoke the thought “I left the stove on”, do not check
  - Finish a task, evoke the thought “I may have made a mistake”, do nothing
  - Walk past people in the mall looking at breasts and evaluating them
  - Go up the stairs counting random numbers
  - Drive over bridge saying “I could yank the wheel”.
  - Steal a cheap pen. Do not return it.
- Script work:
  - Create a story of a minor mistake ending a relationship with catastrophic consequences. Reread and reread.
  - Exposure for “just right” OCD
    - Mess up the closet. Do nothing
    - Leave the house with makeup or hair or clothing away
- Modifications

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Practical Office-Based Exposure

- Play with obsessive thoughts: write them, sing them, translate them, make poems out of them.
- Have patient bring in contaminated objects
- Mess up the office. Eat a cookie after putting it on the floor. Make anonymous phone call.
- Have a dirty thoughts contest. Try killing a pet with thoughts. Imagine disasters in purpose.
- Response modification: Have patient delay, limit, or change ritual. Reduce number of sensory modalities

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What Not to Do When Treating Someone with OCD

- No “replacing negative thoughts with positive thoughts”
- No “changing the mind to rational thinking”
- No “distraction” with physical activity
- No “thought stopping”
- No “breathe” or “relax”
- No rational disputation and arguing probabilities
- Safety behaviors interfere with exposure

The Key

Change the patient’s relationship to his/her thoughts, not the thoughts themselves.

What Makes This So Difficult?

- Distortions from Anxious Thinking
- The Role of Uncertainty and Doubt
- Paradoxical Effort
- Need to Defuse from Cognitive Content

Anxiety Sensitivity

- Fear of symptoms of arousal, unwanted thoughts, and odd sensations
- Intolerance of doubt and uncertainty
- Intolerance and over-interpretation of distress and discomfort
- A heritable trait which is expressed most strongly under conditions of stress and develops a life of its own.

People With High Trait AS

- They are afraid of fear/anxious arousal
- They avoid triggers for anxious arousal
- They have anticipatory anxiety about becoming anxious
- They believe that there will be a point where they “can’t stand it” if they allow anxiety to happen.
- They have likely been raised by someone who has high Trait AS

Anxiety is an Altered State of Consciousness

- It makes thoughts feel dangerous (thought/action fusion, or over-valued ideation)
- Blurs the distinction between cognition and behavior
- Asks for a degree of certainty and safety that we don’t expect in non-anxious areas of our life
Cognitive Distortions

• **Over-importance of thoughts** (Because something crosses my mind, therefore it deserves attention and consideration, or, it means something important about me)

• **Threat/risk probability estimation errors** (Confusion of stakes and odds)

• **Fear of the consequences of anxiety** (My body or mind will break; I couldn’t stand it if...I will lose control)

More Cognitive Distortions

• Belief that **control over thoughts** is necessary or achievable.

• Belief that lack of control over thoughts is **dangerous** (thought/action fusion – threat probability) or indicates **immorality** (thought/action fusion – moral equivalence)

• Inflated sense of **responsibility**

• **Perfectionism** and all-or-nothing thinking

Certainty is a Feeling
Not a Fact

**Intolerance of Doubt or Uncertainty Is Central to OCD**

We Can’t Be Sure of Anything

• Trust in a relationship is a guess

• Safety is always relative and never risk-free

• We cannot be 100% certain of anything including “am I awake now?” “do these people know what they are talking about?”

• Health can disappear without warning in a moment

• Bad things usually come out of left field

• Most big questions are essentially unanswerable (Am I a good enough person? Will my kids be happy? What is the meaning of life?)

What You Resist Persists

There is a paradoxical attitude that is necessary to overcome OCD. Trying to suppress thoughts make them loud, stuck and repetitive. Acceptance of symptoms reduces the suffering over them. Anxious anticipation of them encourages their return.

“An obsession is just a [stuck thought] in a [tired mind]...You will never lose your obsession while you are trying so hard to do so... Let your thoughts play their tricks as they will”

Claire Weekes, 1969
Meta-Cognitive Treatment of Obsessions

- Identify false beliefs about thoughts in general and these thoughts in particular (They are not messages, impulses, facts, or warnings – they are thoughts)
- Use the re-appraisal of the thoughts to give courage to do exposure-based work (create new pathways in the brain)
- Defuse from the thoughts (“I am having the thought that…”)
- Stop efforts at avoiding or suppressing thoughts

How Do You get people to do what they fear to do?

- Explain everything, including the cost of not facing the fears, and the reasons why every other attempt to get better has not worked.
- Use the relationship – empathy, authority, confidence and modeling.
- Praise every step, no matter how small

LEAP OF FAITH:
With Every Step, Tolerate the Uncertainty

- Maybe it is not just a thought or a sensation of arousal, maybe it is actually a warning
- Maybe there is something you are missing
- Maybe your worst fears will be realized
- Maybe you are dying or going crazy or losing control or causing harm right now
- Maybe this way of doing therapy won’t be helpful

The Key to Recovery is Attitude Towards the Content of the Mind

- Use the model that Obsessions are just “Brain Farts” and the content of the Obsession is meaningless
- Decrease resistance to thoughts by making them unimportant
- Draw back and observe thoughts (mindfulness)
- Develop humor and metaphors to teach acceptance
- Thoughts and urges that are not dreaded, avoided, or “controlled” eventually occur less often

Metaphors and Stories

- Bug on the windshield (acceptance)
- Whack-a-mole (surrender)
- Kids in the car seats (surrender)
- Bum at the party (disentanglement)
- Waterfall (disentanglement)
- Drop the rope (paradoxical effort)
- Quicksand (paradoxical effort)
- Chinese finger cuffs (paradoxical effort)

OCD is a Family Affair

- It runs in families. It is often multigenerational.
- It can affect each family member, whether they have OCD or not.
- Family processes do not cause but may well maintain symptoms
- Recovery takes place in a family context

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Relapse Prevention: A Realistic Definition of Recovery

- OCD is a chronic intermittent condition
- Periods of stress will likely provoke the return of intrusive thoughts with accompanying urges to engage in compulsions
- The notion of “cure” is a double-edged sword, in that re-sensitizations will be received as relapse or failure

Recovery: No More Suffering, Not No More OCD

- When the appearance of symptoms doesn’t matter – when intrusive thoughts or images don’t make you do anything different, feel bad about yourself or interfere with living.
- When “hiccups of the mind” can come and go without consequence, compulsion, avoidance or anguish.

Levels of Recovery

- Significant Improvement: Compulsions are far fewer and less impairing
- Remission: Obsessions have abated – but there is fear of relapse
- Recovery: Obsessions do not matter whether present or not.

Psychodynamic Work: Where Does It Fit?

In Relapse Prevention Phase

- In understanding how cognitive distortions came about
- In understanding what patterns, affects, issues tend to re-sensitize
- In dealing with anger and losses in growing up with OCD
- Timing: After Symptom Management is Achieved

Relapse Prevention: Frequency and Intensity of Symptoms Varies With Mood and Stress

- Exercise/play
- Diet/sleep hygiene
- Caffeine/alcohol
- Comorbid conditions
- Family issues
- Mindfulness meditation
- Assertiveness training
- Time management
- Anger management
- Conflict resolution
- Spiritual practice
- Nurture friendships

OCSD and OCPD

- Obsessive Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania (hair-pulling) Disorder
- Excoration (skin-picking) Disorder
- OCD caused by substances, medical conditions or other
- Separately: obsessive compulsive personality disorder -- ego-syntonic, pervasive and more of a problem to others ...
**Take Home Message:**
Willingness to Be Uncomfortable

No technique, coping skill, or exposure practice will work if the patient remains afraid of, trying to avoid and struggling against:
- sensations of arousal or discomfort
- the intrusions of anxious thoughts
- the inevitability of doubt and uncertainty

*This is the basic paradox to be learned and accepted over time.*

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**Websites of Note**

- IOCDF.org
- ADAA.org
- OCDonline.com
- Anxieties.com

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**Contact Information**

- [www.drmartinseif.com](http://www.drmartinseif.com)
- [www.anxietyandstress.com](http://www.anxietyandstress.com)
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