Oxford Health Specialist Psychological Interventions Centre
Cognitive Behaviour Therapy (CBT) for Obsessive Compulsive Disorder (OCD):
Guidance for working remotely

When working remotely with people with OCD, using Skype, Zoom etc., you can use the same treatment components in the order that is recommended for face-to-face treatment. Some aspects of treatment may require some problem solving e.g. how to make a recording for the person to listen back to the session. The key initial tasks are: (i)the therapist and service user getting to know each other; (ii) gaining a shared understanding of the problem and how it affects the person; and, (iii) generating a less threatening alternative belief that makes sense of the difficulties. These initial tasks leading on to clearly identifying goals for treatment, planning and executing behavioural experiments which include 'exposure' to physical or mental situations usually avoided or endured with high anxiety while not carrying out (or planning) any compulsive behaviours (response prevention). The 'exposure' and 'response prevention' components of CBT treatment are required for effective treatment, after suitable preparation. All of this is directed towards helping the person to reclaim the things which are important in their life and which have been lost to or prevented by their OCD. Please note that we regard it as best practice for those who are unable to participate online (or who strongly prefer not to) to interrupt treatment until a more acceptable format is available.

As a process of developing a shared understanding and working out how to challenge the beliefs that maintain OCD, the steps in CBT treatment for people with OCD are:

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 these work. Lists of commonly occurring intrusive thoughts can be foundat the end of this document (see Appendix A) and online (https://www.ocduk.org/ocd/obsessions/). It can be helpful to share 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).
Collaborative formulation using the 'vicious flower' structure.
This step is to help the person to understand why their intrusive thoughts / obsessions are so upsetting, and why they are so persistent and create the urge to carry out compulsive behaviours, thoughts and excessive avoidance. This usually

involves constructing a diagram based on the shared understanding, referred to by therapists as formulation. Often this takes the form of a vicious flower, derived from the detailed discussion of a recent, specific, typical example of the difficulties: identifying intrusive thoughts, the threat and responsibility appraisal and neutralising/safety-seeking behaviours, avoidance and selective attention, and how these elements reinforce each other leading to the maintenance of OCD.

This can be undertaken using a shared file open to both users, or via a 'whiteboard' available on some platforms. It is also possible for the therapist to share their screen which would allow them to draw out the vicious flower. If this is not possible for the service user (for example if they have a phone capable of video conferencing but no laptop / other device) then talk through the formulation and send as a photo. Service users might then be asked as homework to try to do a similar diagram/formulation of a different situation and to send a photo back to their therapist.

Just as in face to face therapy, service users will be asked to complete questionnaires to help them and the therapist increase awareness of changes as time goes on.

Theory A / Theory B
This can be undertaken using a password protected shared file (e.g. using google drive or DropBox) showing a table with the relevant headings. As above, if this is not possible, the therapist can send a blank copy to the service user to aid discussion. As normal, theory B (the alternative, less threatening account) should include some notion of why the person is experiencing their problems (e.g. you are a clean person afraid of being dirty, a careful person concerned about making mistakes). See below for further discussion of theory A / theory B relevant to Covid19.

Discussion techniques aimed at reducing the belief in the threat appraisal
These can be carried out as usual, reminding the service user to take notes to summarise the discussion particularly if they are not recording the session. Asking the service user to make a small number of notes (bullet points on what they have learned in the session, no more than 6-10 items) can be helpful. Also to make notes about anything which they wanted to clarify at the next session. If used, make sure that you include these in the agenda. (See Appendix B for an example a note taking form for the service user).

Planning behavioural experiments to disprove Theory A and / or build up evidence for Theory B
So far, with some minor adjustments, therapy by remote looks pretty much like the face to face version. However, the adjustments required for behavioural experiments and exposure 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 the 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 service user 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 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 service user 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. It can be helpful for the therapist to prepare a short summary of the main points dealt with in the session and email it to the service user as soon as possible, ideally by the end of next day.

Relapse prevention planning

This is generally a shared written document with a summary of what has been learned in treatment and how to be prepared for setbacks. (See Appendix C for an example of a 'Blueprint'). An alternative format is using audio or video instead of written materials. This can be worked on together in sessions or emailed between therapist and service user.

Going online: What's the same and what's different
The same:
Set a clear agenda at the beginning of each session.
Sessions will typically be the same kind of length as you usually do
The structure and focus of therapy is the same, just a different way of delivering it
Tracking changes through the regular use of questionnaires completed by the service user
Different:
You are not in the same room!
Behavioural experiments need to be modified to allow for inflexibility in terms of where you can go and how you can do it, support the person and model activities. Some people with contamination fears throw away food because it may be contaminated. During the lockdown, its harder to replace food and other items, and people with contamination fears may be even more concerned about their supplies, so you need to make sure that they have the essentials for daily living, including but not confined to sufficient food.

Some other considerations

At the best of times, it can be very difficult for the families and loved ones of those experiencing OCD. During this stressful time, therapists may want to consider offering more support to those affected by and supporting the sufferer. This might mean providing some sessions for the carers.

Consider stepping up risk assessment especially when those close to service users are affected by the virus or when the service user seems to be becoming overwhelmed by the Coronavirus worries. Risk of self harm and suicide will be generally raised by the psychological impact of isolation as well.