Obsessive-Compulsive Disorder

Patient Treatment Manual

This manual is both a guide to treatment and a workbook for persons who suffer from Obsessive-Compulsive Disorder. During treatment, it is a workbook in which individuals can record their own experience of their disorder, together with the additional advice for their particular case given by their clinician. After treatment has concluded, this manual will serve as a self-help resource enabling those who have recovered, but who encounter further stressors or difficulties, to read the appropriate section and, by putting the content into action, stay well.

From: *The Treatment of Anxiety Disorders*.
Andrews G, Crino R, Hunt C, Lampe L, Page A.
New York: Cambridge University Press (1994)

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Section 1

1. The Nature Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is an anxiety disorder that, until quite recently, was regarded as a rare condition. Recent studies have shown that OCD is considerably more common than previously thought and as many as two in every hundred people may suffer from the condition.

OCD is characterized by persistent, intrusive, unwanted thoughts that the sufferer is unable to control. Such thoughts are often very distressing and result in discomfort. Many OCD sufferers also engage in rituals or compulsions that are persistent needs or urges to perform certain behaviors in order to reduce their anxiety or discomfort. Often the rituals are associated with an obsessional thought. For example, washing in order to avoid contamination follows thoughts about possible contamination. For some, there is no apparent connection between the intrusive thought and the behavior for example, not stepping on cracks in the sidewalk in order to avoid harm befalling one's family. Others still have no compulsive behaviors and suffer from obsessional thoughts alone, while others do not experience obsessions but have compulsive rituals alone.

The one common element to the various symptoms in OCD is anxiety or discomfort. For those suffering both obsessional thoughts and compulsive rituals, it is the anxiety or discomfort associated with the thought that drives the ritual. In other words, the ritual is performed to reduce the anxiety produced by the thought. For those suffering from obsessional thoughts alone, anxiety is often associated with the thought, and mental rituals, distraction, or avoidance may be used to lessen the discomfort. It is much the same for those with compulsive rituals alone in that the behavior is performed in order to lessen the urge to ritualize. The role of anxiety is important in OCD and will be discussed in much greater detail in subsequent sections.

Most OCD sufferers can see the uselessness and absurdity of their actions but still feel compelled to perform their various rituals. They know that their hands are not dirty or contaminated and they know that their house will not burn down if they leave the electric kettle switched on at the wall. Because they are aware of how irrational their behavior is, many sufferers are ashamed of their actions and go to great lengths to hide their symptoms from family, friends, and, unfortunately, even their doctors. It is extremely important that your therapist is aware of all of your symptoms no matter how embarrassing or shameful they may be, as this is the only way that a suitable treatment program can be designed for you. Rest assured that a therapist experienced in the treatment of OCD will have heard of symptoms worse than yours many times over.

1.1 Symptoms Obsessive-Compulsive Disorder

Obsessional thoughts are usually concerned with contamination, harm to self or others, disasters, blasphemy, violence, sex or other distressing topics. Although generally called thoughts they can quite often be images or scenes that enter the sufferer's mind and cause distress. For example, one sufferer may have the thought "My hands are dirty" enter his head. This thought will trigger washing rituals. Another sufferer will actually have enter his head the scene of his house burning down. This scene will trigger checking rituals. Individuals who suffer obsessions alone may also experience thoughts, images, or scenes. For example, someone who has obsessions about harming

his or her children may have the thought of harming them or have a frightening scene of hurting them or an image of the children already hurt.

As was pointed out earlier, many obsessions produce anxiety or discomfort that is relieved by performing rituals. The most common rituals are washing and checking, although there are many others such as counting, arranging, or doing things such as dressing in a rigid, orderly fashion. Although rituals are performed to alleviate the anxiety or discomfort that is produced by the obsession, the anxiety relief is usually short-lived. An individual who washes in order to avoid or overcome contamination will often find him- or herself washing repeatedly, because either they were uncertain whether they did a thorough enough job or because the obsessional thought that they are contaminated has recurred. Similarly, someone who checks light switches, stoves, and so forth in order to avoid the house burning down, often has to repeat the behavior over and over, because he may not have done it properly or the thought or image of his house being destroyed has recurred. Even individuals who have obsessional thoughts alone may find that they have to repeat the cognitive rituals such as counting or praying many times over as they may not have done them *perfectly* in the first place.

An important point to keep in mind is that many sufferers have more than one type of symptom so that individuals may engage in more than one type of ritual or have more than one type of obsessional thought. Another point to note is that symptoms change over time and someone who is predominately a washer may, over time, develop checking rituals that eventually supersede the original complaint. In addition to changes in symptoms, the course of the disorder may also fluctuate over time, with periods of worsening and periods of improvement. Other sufferers may find that their symptoms remain static, while yet others may find a gradual worsening of symptoms since the onset of the disorder.

For many sufferers of OCD, these symptoms take up a great deal of time, often resulting in their being late for appointments and work and causing considerable disruption and interference with their lives. Apart from disrupting their own lives, it also frequently interferes with the lives of family members as the typical sufferer often asks the other members to do things a certain way or not to engage in certain behaviors, as this may prompt the sufferer to engage in rituals. Thus, the symptoms are not only controlling, frustrating, and irritating to the patients, but also to their family, friends, and workmates.

Avoidance of certain situations or objects that may trigger discomfort and rituals is also quite common among OCD sufferers. It seems logical to avoid contact with contaminants if you are a person who washes compulsively, or to avoid going out of the house if you must check all the electrical equipment, the doors, and windows. While this seems like a reasonable way of coping, it actually adds to the problem, as the typical sufferer avoids more and more situations and gradually the problem comes to rule their life. Second, avoidance does little to deal with the problem as it only serves to reinforce the idea that such situations are dangerous. Because the situation or object is constantly avoided, there is no opportunity for the individual to learn that there is no danger.

Section 2

2. The Causes and Treatment OCD

To date, no one is certain of the causes of OCD. Though there are a number of theories that attempt to explain the development of the condition, there is little evidence to support them. We know that for some the onset is during childhood, while for others, the onset may be during adolescence or early adulthood. We also know that in some cases the onset is sudden, while others have a slow, insidious onset. Some of the theories that have been proposed to explain the development of OCD follow.

2.1 The Biochemical Theory

This theory was put forward after it was found that certain medications were of benefit in the treatment of OCD. These drugs mainly affect one type of chemical in the brain called serotonin. Consequently, it was hypothesized that a problem with serotonin could be the cause of OCD. Although the drugs are indeed effective in the treatment of this condition, there is little hard evidence to indicate that sufferers have a deficit of serotonin in their brain.

2.2 The Genetic Theory

This theory was put forward to explain the finding that OCD can sometimes occur in families. Although a genetic predisposition may account for some sufferers developing the condition, there is also the strong possibility that the OCD behavior was learned from the parents or siblings. It is extremely difficult to differentiate between OCD behavior thay may be the result of genetics or OCD behavior that may be the result of the environment.

2.3 Learning Theory

This model suggests that obsessive-compulsive behavior has been learned through a process of conditioning. Put simply, this theory states that a neutral event becomes associated with fear by being paired with something that provokes fear, anxiety, or discomfort. This fear then generalizes so that objects as well as thoughts and images also produce discomfort. The individual then engages in behaviors that reduce the anxiety and because the behavior is successful in reducing anxiety even if only for short periods of time it is performed each time discomfort or anxiety is felt. The problem with this theory is that it fails to explain why particular fears such as contamination or of harm to oneself and others commonly occur in OCD. Another problem is that many sufferers do not recall any significant precipitating event that can explain the onset of their symptoms. However, this theory does explain how obsessive-compulsive symptoms are maintained, and as a result, this issue will be dealt with in much greater detail in subsequent sections.

2.4 Psychoanalytic Theory

This theory basically states that obsessive-compulsive symptoms are attempts to keep unconscious conflicts and impulses from conscious awareness. Unfortunately, there is little evidence to support this theory and psychoanalysis is of little value in the treatment of the majority of OCD sufferers. As can be seen, no theory is able to adequately explain the development of OCD but that does not mean that there are no effective treatments. In fact, the cause, though of considerable interest, has little bearing on treatment outcome. It is important to note, however, that in some cases symptoms that resemble OCD may be the result of other illnesses such as depression and schizophrenia. Effective treatment of these conditions will

generally result in a decrease in the OCD-like symptoms. Other conditions that may result in symptoms that resemble OCD are Tourette's Syndrome, dementia, brain trauma, or other neurological disorders.

2.5 The Treatment Obsessive-Compulsive Disorder

There are currently two effective treatments available for OCD that may be used separately or together. One is drug treatment, with medication that increases the availability of serotonin in the brain; the other involves the use of behavior therapy techniques. At present, it appears that they are both effective and there is little in the scientific literature to suggest that combining the two results in a better outcome than using them individually. However, some sufferers who find behavior therapy too difficult initially may benefit from a course of medication so that effective behavior therapy can be undertaken.

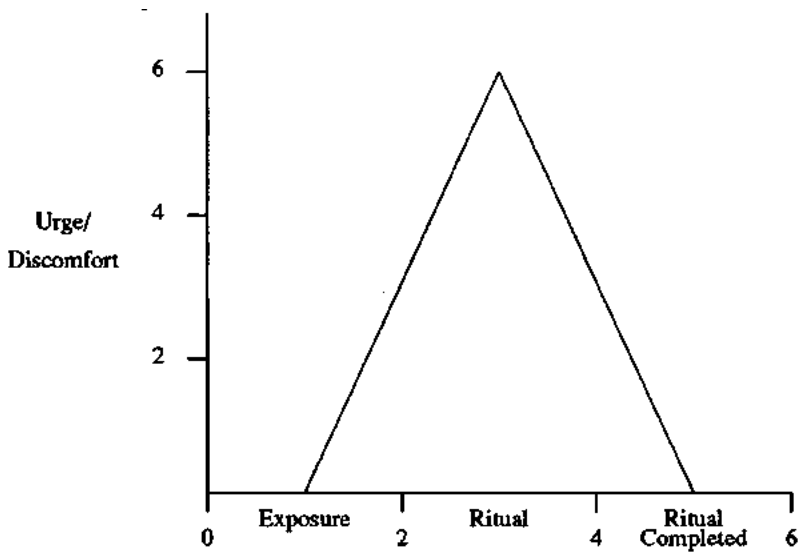
2.5.1 Medication

The medications that have been found to be particularly helpful in the treatment of OCD come from the antidepressant family of drugs and include clomipramine, fluoxetine, fluvoxamine, and sertraline. They have specific effects on serotonin levels in the brain. Serotonin is the biochemical substance that some researchers believe is involved in OCD. In general, these medications have been shown to be effective for some OCD sufferers and assist them in bringing their symptoms under control. If one of these medications is prescribed for you, you should be made aware of possible side effects and report their occurrence to your therapist. It is important to remember that these medications are not a cure for OCD. In addition, research indicates that ceasing the medication in the short term generally results in a return of symptoms. It could be that sufferers need to remain on the medication for long periods of time or that behavior therapy should be used in conjunction with the drug.

2.5.2. Behavior Therapy

The rationale for using behavioral techniques is briefly explained in the learning theory section above but it is important enough to state again in greater detail. Typically, the OCD sufferer has intrusive thoughts that generate anxiety, discomfort, or an urge to carry out a ritual. Performing the ritual results in a decrease in anxiety or discomfort, so that performing the ritual is actually reinforcing through its ability to reduce these negative feelings. For example, an individual has the thought that his or her hands may have touched something dirty or contaminated. This thought produces anxiety in that the person feels uncomfortable about the possibility of being contaminated or contaminating someone else. This unpleasant anxiety or discomfort is relieved by washing of the hands or other contaminated objects and it feels good to rid oneself of such negative feelings, so it feels "good" to wash. In the same manner, an individual who must check the stove and heaters prior to leaving home in order not to cause a disastrous fire will feel some relief after checking these items many times to ensure they are off. Thus the anxiety-producing thought is temporarily minimized by checking, and it feels "good" to check.

This anxiety- or discomfort-reducing quality that the rituals possess is shown in the following graph. Patients were asked to rate their levels of discomfort and urge to ritualize (1) before being exposed to an anxiety-evoking stimulus, (2) after being exposed, and (3) after performing their rituals. As can be seen, exposure to the stimulus results in a marked increase in discomfort and urge to ritualize. Engaging in the ritual brings about an immediate and dramatic decrease in both these measures.

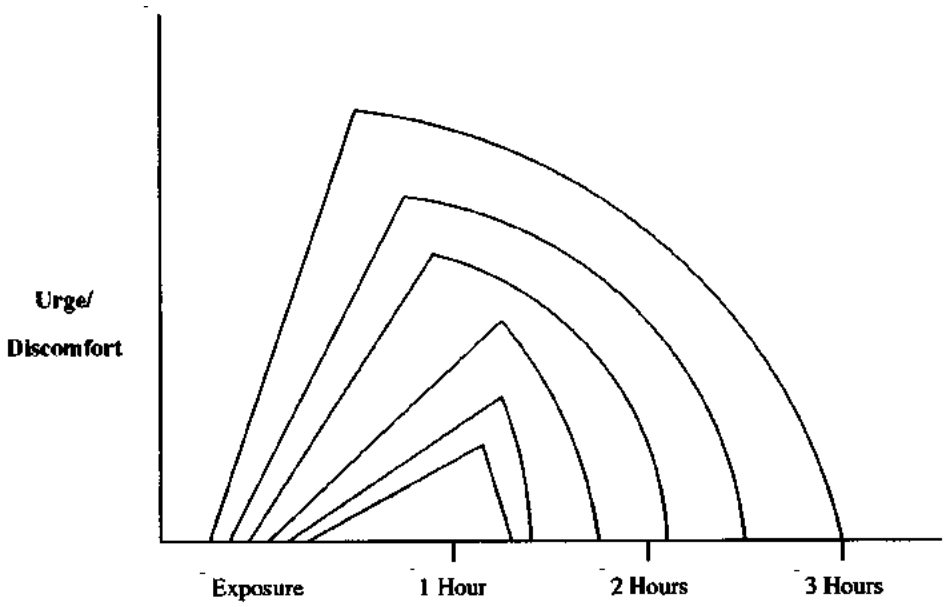


Though the decrease may be short-lived, the individual very quickly learns that the discomfort may be reduced again by performing the ritual. The more anxious the individual feels, the more ritualizing they engage in. This is further worsened by their inability to concentrate on what they are doing to the extent that they are unsure that the ritual was conducted properly. This adds to their anxiety, which they try to bring under control by ritualizing further. For example, an individual who checks electrical equipment, doors, and windows prior to leaving home learns very quickly that checking alleviates the discomfort associated with the thought that the house may burn down or be broken into. The individual may have to perform the checking rituals a number of times in order to gain some relief. If he or she is under pressure from other sources and is preoccupied or distracted by these other worries, then they will have to engage in the rituals many more times because they may not have been done "correctly" the first few times. Having seen how compulsive rituals are maintained, the important question is what can be done to break the vicious cycle between the discomfort-producing thought and the anxiety-reducing rituals Again, research into the condition provides the answer.

Section 3

3 Exposure and Response Prevention

Investigators looking at the phenomenology of OCD examined what happened when sufferers were exposed to stimuli that triggered rituals and were asked not to engage in their rituals. Initially, there was a significant rise in anxiety, discomfort, and urge to ritualize. Rather than continue to get worse, however, this rise remained quite steady and then gradually decreased so that by the end of the session, the level of discomfort had almost returned to normal. When this process was repeated again and again, the surprising finding was that the initial discomfort and anxiety was less with each exposure and the time taken to return to normal was shortened so that eventually exposure to the stimulus would result in a "hiccup" in anxiety that would then quickly settle. The initial findings of this research are demonstrated in the following graph.



These findings led to the development of the behavioral treatment known as exposure and response prevention. As the names suggest, the two elements of this treatment are:

- exposure to the cues or triggers of the compulsive rituals, and
- prevention of the ritualized response

Prevention does not mean that the person suffering from the condition is restrained or held back from performing the ritual but rather that the individual, with the help of the therapist, voluntarily does not engage in the ritual.

In repeating this process of exposure combined with response (ritual) prevention, the end result is one of perhaps mild discomfort when confronted with triggers for the rituals, but the most

important change is that the individual is now in a position to control the problem rather than having it control him or her.

When sufferers are made aware of this form of treatment, the initial reaction is either one of disbelief that such simple methods may work or alternatively that it appears extremely difficult. First, this form of treatment is not as simple as it seems. The approach must be structured, planned, and systematic in order to have maximum benefit. The individual needs to be motivated and consistent in his or her efforts to overcome the problem and faithfully follow all homework and clinic assignments. Approaching the problem in a haphazard manner will invariably result in a less than optimal outcome, with sufferers feeling disappointed, frustrated, and hopeless. A consistent and planned approach ensures that the problem is dealt with in a systematic manner. Any difficulties encountered can be quickly dealt with by the patient with the assistance of the therapist. Second, for those who see this approach as too difficult, the fact that the treatment program is planned by you in conjunction with the therapist ensures that the pace is at a level you are capable of mastering and the various steps can be graded to maximize your chances of success.

3.1 Obsessional Thoughts

The principles of exposure and response prevention are also applied to the treatment of obsessional thoughts and images, except that there are no obvious behavioral rituals to work on. This does not mean that someone who has int rusive thoughts does not engage in rituals to reduce anxiety and discomfort; it is just that the rituals may also be thoughts. If, for example, an individual with OCD experiences frequent blasphemous thoughts, he or she may attempt to reduce the discomfort by saying a short prayer to him- or herself. Similarly, individuals who have thoughts of harming their children will often deal with the anxiety that such a thought produces by trying to push it out of their head or by desperately reassuring themselves that they love their children and would never harm them.

Other sufferers with obsessional thoughts alone often have more elaborate and definite rituals. For example, having to mentally retrace their steps to ensure they did not harm anyone while driving to their destination, or having to remember whether anything sharp stuck into their body because they fear contracting AIDS, or having to say something a certain number of times in order to avoid some disaster. When the problem of obsessional thoughts is conceptualized in this way, the treatment for the condition is readily apparent and involves exposure to the anxiety-provoking thought while, at the same time, not engaging in cognitive or mental rituals to lessen the discomfort.

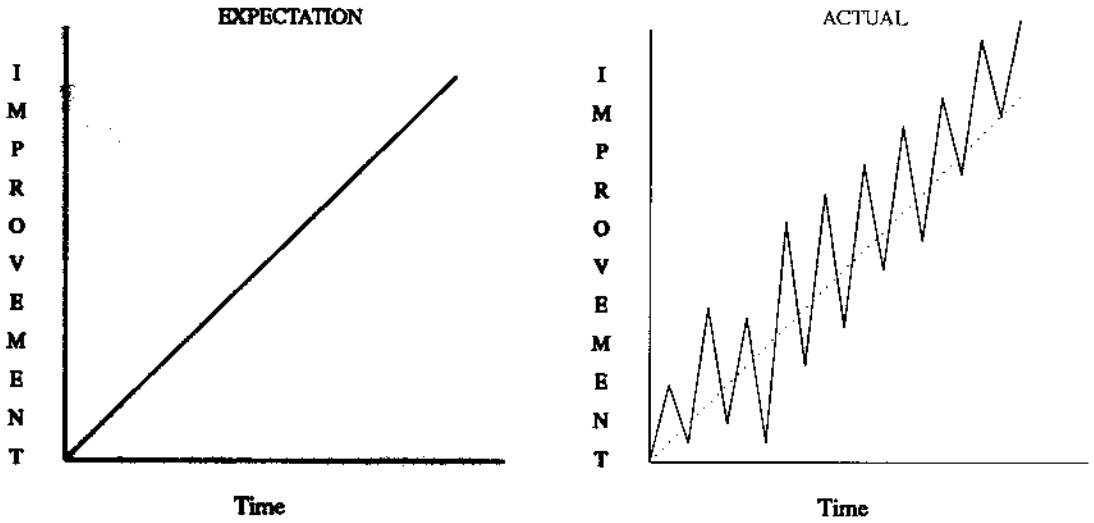
There are, however, some important differences in the treatment of obsessional thoughts, especially considering that exposure to thoughts is not as easy as exposure to concrete objects: Treatment involves confronting the thought or image until it no longer causes the individual distress or discomfort. For those who suffer from obsessional thoughts, this may seem to be an impossible task, but when you consider that everyone experiences unpleasant, strange, or bizarre thoughts, then the goal of treatment appears more realistic. The major difference between obsessionals and everyone else is the meaning they attach to their intrusive thoughts. An individual who does not suffer from OCD will experience an intrusive thought but will dismiss the thought as silly and it will be gone. If it does recur, then it is again regarded as silly and meaningless and dismissed. Someone suffering from OCD, however, may experience the same thought and will desperately try not to think about it or will try to think of something to negate or cancel the thought. In other words, they react with fear, dread, and anxiety, so that the chances of the thought recurring and causing further distress is greatly heightened. Attempts to not think

about the thought is like trying to not think of a pink elephant, whereas attempts to negate it through mental rituals only serve to reinforce the thought's apparent power. Put simply, it's your fear of the thought that ensures its continued return and your continued distress. The object of treatment is to disengage the emotional meaning of the thought from the thought itself so that is becomes "just another thought." This result is achieved through the exposure program.

Exposure should not only involve the obsessional thoughts but also must include any situations that the individual has been avoiding because of the possibility that the thoughts may be elicited. For example, a sufferer who fears harming his or her children may avoid contact with knives or other sharp objects while the children are around, or someone with blasphemous thoughts may avoid going to church for fear of bringing on the thoughts while there. Avoidance of such situations needs to be overcome in order to maximize and maintain the gains made from treatment.

3.2 Basic Rules for Success

The first requirement for the success of this treatment is motivation. Overcoming OCD is difficult and requires persistent effort on the part of the sufferer. Obviously, there will be periods when treatment is going smoothly and others when the progress is slow and difficult. The important points to bear in mind are that the problems have been with you for a considerable period of time and are probably well ingrained in your daily routine. Overcoming these difficulties will most certainly take time and you should allow yourself as much time as it takes to get yourself better. You don't need to add to your difficulties by being impatient. Second, progress is not in a straight line but tends to be fluctuating so that having occasional bad days is the rule rather than the exception. The two graphs below are to demonstrate the difference between what people expect to happen and what actually happens.



The response to treatment that most people expect is linear, in that they start treatment and expect to get better and better. What actually happens, however, is that there are fluctuations from day to day with some days being worse or better than others. When the fluctuations in the second graph are evened out (dotted line), it becomes obvious that the individual is improving even though at times it may not feel as though they are getting better. They may even feel as though they are slipping back. It is important to reassure yourself that having a bad day does not mean that the situation is hopeless or that you are back to square one. In fact, the only individuals sure to return to square one are those who lose their motivation and no longer persist with the program.

Another basic requirement for a positive outcome is, for want of a better word, honesty. You need to be honest with yourself and your therapist in terms of your fears, avoidance, rituals, and thoughts. At times, individuals who know they have to be exposed to situations they have avoided for long periods of time will avoid telling the therapist about similar situations or will not complete homework assignments. This does nothing to help the sufferer overcome the problem in any way. Telling yourself that the problem will be dealt with later is just another form of avoidance. It is important that you keep your therapist informed of your progress, difficulties, and fears at all times so that, if need be, the program can be modified to suit your needs. Others may avoid telling the therapist important information because they are embarrassed by the content of their thoughts or the nature of their rituals. Keeping this information to oneself means that the treatment program will not be comprehensive and ensures that the outcome will not be as successful as it could have been. As stated before, your therapist will have dealt with many OCD sufferers and no doubt will have heard of problems such as yours many times over. These types of thoughts and rituals are quite common among sufferers, even though they may seem bizarre or strange to you.

Another important issue ties in with motivation. By attending the clinic, you have decided that it is time to work on your OCD problems. That is exactly what you should focus on doing to the exclusion of all else except the essentials. Your progress will be impeded if you have to deal with other issues such as moving to another house, leaving your partner, starting a new job, and so forth. It is essential that you set aside the time to work on your problems without the distraction posed by these other issues. If distractions are pressing, deal with them before commencing treatment and allow some time for yourself to come to terms with the changes.

The final important issue is that of self-mastery.

As you progress through the program, you will gradually gain confidence in dealing with the OCD problems. In order to gain this sense of mastery over the problem, it is essential that you do not use anxiety-reducing drugs, illegal drugs, or alcohol while participating in the program as use of such substances results in your attributing positive changes to the drugs rather than to yourself.

Section 4

4. The Treatment Program

In previous sections an outline of the rationale and principles of treatment have been discussed. This section will review some of the important points and discuss the design of your treatment program. As mentioned above, treatment consists of repeatedly exposing the individual for prolonged periods (45 minutes to two hours) to circumstances that produce discomfort. In the initial sessions, such exposure will be under the supervision of your therapist who will be with you throughout the task. Sessions may be conducted at the clinic, at your home, or in other settings where the rituals are a problem. The exposure is graded so that moderately disturbing situations are effectively dealt with before proceeding with more difficult ones. By breaking down the problems into steps and mastering each step before moving on to the next one, you will find that what may seem like insurmountable problems become manageable. The sessions are held daily, with daily homework tasks being set during each session.

The importance of homework tasks cannot be overestimated, as it is with performance of these tasks that most of the treatment gains will occur. It is of little use to only engage in the exposure and response prevention while at the clinic. By completing your homework tasks faithfully, you are ensuring that what is being achieved at the clinic will transfer to the outside environment as well as reinforcing what has been learned during each session. Throughout the exposure, individuals are requested to refrain from ritualizing, regardless of the urges to do so. You should be prepared to experience some discomfort but you can rest assured that it will be considerably less than what you will anticipate. In fact, this is one of the major difficulties when describing this type of treatment to patients. Most sufferers fear that when exposed to a stimulus that evokes discomfort their anxiety will continue to rise for as long as they do not perform the ritual, until it eventually becomes unbearable. This is not the case. As described in previous sections, the discomfort will peak and then gradually decay, and each subsequent exposure will be less distressing and the decay will occur more rapidly.

4.1 Program Design

The first step in designing your individual program is to conduct a thorough analysis of your difficulties by breaking down the problem into its various components.

A. CUES OR TRIGGERS

In the space below, please list the objects, situations, or circumstances that cause you discomfort or anxiety in regards to your OCD. What are specifically being looked for are the triggers to your rituals. Once you have listed them, your therapist will help you rate them in terms of their discomfort evoking abilities.

	Cue or Trigger	SUD
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

B. INTERNAL CUES OR TRIGGERS

In this next section, please list the internal cues that may cause discomfort. These may be thoughts (my hands are dirty, is the iron off?, I will harm my child, etc.), images, feelings, and impulses. Once again, when the list is completed, your therapist will help you rate them as regards their anxiety-causing potential.

	Internal Cue or Trigger	SUD
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

C. RITUALS

In this section, please list the type of rituals that you engage in to lessen your discomfort. If you have developed daily routines that are not in response to direct stimuli (e.g., having a one-hour shower daily, washing or checking in a particular manner), please list them as well.

	Rituals	SUD
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

D. AVOIDANCE

In this section, please list all situations, objects, etc. that you avoid because they will cause you discomfort.

	Avoidance	SUD
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

4.2 Exposure Tasks

The next phase in developing your program is to actually determine the exposure tasks and timetable them according to your ratings of discomfort so that, to begin with, you will be exposed to the least anxiety-provoking situation.Once this is mastered, you will move on to the next more difficult item.

Before moving on to this next phase, it is important to establish some ground rules with your therapist. The purpose of these rules is to ensure that you gain maximum benefit from treatment.

> *First,* there need to be some limits set on your ritualized behaviors. If you wash compulsively, then certain limits will be set as to when you can wash, for how long, how much soap can be used, and so forth. If you check compulsively, there will be limits put on what you can check, how often, and so forth. These limits are to be in force 24 hours per day. The reasons are really quite obvious. If you are exposed to a situation or object that causes you discomfort and then resist the urge to ritualize for the required period, there is little gained if you subsequently engage in rituals because you have come in contact with some other stimulus. These rules will be set each week in consultation with your therapist.

> *Second,* there is to be no enlisting of family members to perform your rituals. For example, having them wash clothes or floors, or check doors, the stove, and so forth. By getting family members to do such things for you, you are in fact feeding the problem rather than overcoming it. Members of the family can certainly be enlisted to help you with your exposure tasks and your response prevention, but they should not be used to maintain the problem.

In the following sections, you and your therapist will list the ground rules for each week as well as the planned daily tasks and the homework assignments. There will also be the opportunity for you to make note of any difficulties encountered during the program.

Toward the end of the program, a new phase called overlearning will be introduced. This phase is an important part of treatment during which the exposure tasks are designed to ensure the consolidation of what has been learned during treatment. Your therapist will discuss this process with you when the time arises.

	Week One – Ground Rules
1	
2	
3	
4	

	Week Two – Ground Rules
1	
2	
3	
4	

	Week Three – Ground Rules
1	
2	
3	
4	

	Permanent Rules
1	
2	
3	
4	
5	

EXPOSURE SESSION

Session Number: _____ **Date:** _____

Exposure task _____

_____

_____

Time spent in task _____

Difficulties _____

_____

Homework exposure _____

_____

_____

Time spent in task _____

Difficulties _____

_____

Comments _____

_____

_____

Recommended Reading

5. Recommended Paperbacks

The following books are available from most large bookstores, many smaller ones, and some newsstands. If in doubt, ask if the book can be ordered. We also suggest that you use your local library to gain access to many of these books. When you read these or any similar books on the management of anxiety, remember that they are best regarded as guidelines only. Be critical in both a positive and negative sense when reading these books, so that you get what is best for you out of them. Most of these books are inexpensive.

Marks I. (1978) *Living with Fear.* New York: McGraw-Hill.

Steketee G, White K. (1990) When Once Is Not Enough: Help for Obsessive Compulsives. Oakland, Ca: New Harbinger Publications.