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EMPIRICALLY GROUNDED CLINICAL GUIDANCE PAPER

Understanding why people with OCD do what they do, and why other people get involved: supporting people with OCD and loved ones to move from safety-seeking behaviours to approach-supporting behaviours

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Abstract

The distress inherent in obsessive compulsive disorder (OCD) can often lead to partners, family members and friends becoming entangled with the OCD in terms of being drawn into performing certain behaviours to try and reduce the distress of their loved one. In the past this has often been referred to somewhat pejoratively as collusion, or more neutrally as accommodation. In this paper we emphasise that this is usually a natural human response to seeing a loved one in distress and wanting to help. This paper provides detailed clinical guidance on how to understand this involvement and how to include others in the treatment of OCD along with practical tips and hints around potential blocks that may require troubleshooting. It also details the relatively recently introduced concept of approach-supporting behaviours, and provides guidance on how to distinguish these from safety-seeking behaviours. The 'special case' of reassurance seeking is also discussed.

Key learning aims

(1) To illustrate the importance of understanding the person's OCD beliefs 'from the inside' including the internal logic that leads to specific behaviours.
(2) To understand the ways that key individuals in the lives of people with OCD can become entangled with the OCD (through the best of intentions) and to provide practical clinical guidance for CBT therapists around how to engage and work with these individuals in the lives of people with OCD.
(3) To explain and delineate the idea of approach-supporting behaviours, distinguishing these from safety-seeking behaviours.
(4) To distinguish the interpersonal component of reassurance from the neutralisation component and provide guidance on how we can help family members to replace reassurance with something that is equally or more supportive whilst not maintaining the OCD.

Keywords: approach-supporting behaviours; CBT; ERP; family involvement; obsessive compulsive disorder; safety-seeking behaviours

Introduction

This article has been written as an Empirically Grounded Clinical Guidance Paper (Cambridge University Press, 2021). These paper types aim to summarise the current state of a field where there is limited empirical data, and synthesise what is empirically known from related areas

together with observations and learning from significant clinical experience to provide practical guidance to CBT therapists. By their nature, not every suggestion can be evidence-based at this stage, but we endeavour to be transparent on what is clearly based on research and what is based on the significant experience of the second and third authors.

The paper has two main sections; these are linked by theory but have two slightly different aims. The first section aims to provide basic clinical guidance on how to help people with obsessive compulsive disorder (OCD) and family members (or those around them) understand their difficulties through using their own language (this section will be particularly helpful for therapists working with OCD early on in their career). This section is in line with a recent set of guidelines delineating the key knowledge and competencies required to work effectively with individuals with OCD (Sookman *et al.*, 2021) where the authors detail a range of required competencies for family-based interventions for OCD including how to assess the role of family involvement in OCD and provide a range of interventions (from psychoeducation to involving families in treatment to reduce accommodation and behaviours that might act as barriers to homework completion). The current article is largely adapted from a workshop delivered by the third author several times to groups of people with OCD and those supporting them (Freeston, 2020). The latter part of this article extends the workshop and develops the theoretical understanding of behaviours from the initial conceptualisation of safety-seeking behaviours (Salkovskis, 1991), through the empirical work of Freeston and Ladouceur (e.g. Freeston and Ladouceur, 1997; Ladouceur *et al.*, 2000), the clinical analysis by Thwaites and Freeston (2005) and the programmes of research by Purdon and colleagues (e.g. Bucarelli and Purdon, 2015; Dean and Purdon, 2021) and Radomsky, Rachman and colleagues (e.g. Rachman *et al.*, 2008; Milosevic and Radomsky, 2008) in emphasising the function rather than the form of behaviour. It then goes on to unpack the more recent concept of approach-supporting behaviours (ASBs), first delineated by Salkovskis and Millar (2016), and aims to distinguish these from safety-seeking behaviours (SSBs) which are maintaining the OCD. This section of the paper is aimed at therapists at all levels working with OCD.

Although these ideas have been grounded in the generous sharing of experiences by people with OCD (both within workshops and also clinical practice), we recognise that future development needs to include a full range of individuals with OCD, and we would welcome further feedback on our suggestions around approach-supporting behaviours.

Working with people with OCD and family members to help them understand the basic CBT model of OCD

There are several different variants of the CBT model of OCD (e.g. Abramowitz and Jacoby, 2014; Doron *et al.*, 2016; Freeston and Ladouceur 1999; Julien *et al.*, 2016; Rachman, 1998; Rachman, 2004; Radomsky *et al.*, 2018; Salkovskis, 1985), some of which are generic explanations and some are for specific subtypes. However, they largely have in common the idea that people experience intrusive thoughts, which are a normal phenomenon, they make sense of them in a particular way leading to perceptions of threat and responsibility for harm, and then people try too hard to remove the thoughts or reduce the harm by a series of observable and unobservable (i.e. overt behavioural or hidden mental) strategies. Although the way models are presented to professionals can provide clarity and use a 'cognitive therapy language', it is often important to provide a narrative account in everyday language, and use personalised language to help people with OCD to understand their difficulties. The maintenance of the obsessions could be explained to people with OCD and their families using something similar to the example below with adaptations for the particular content.

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CBT therapists typically aim to be Socratic in helping people understand CBT models and subsequently in developing a shared individual formulation. The concepts below could be communicated via Socratic dialogue but there are likely to be times when direct explanations of the model are required, and Socratic dialogue can be used to help their understanding of the model to be applied within an individualised formulation. This applies to many of the examples of text that could be used within this article, so therapists should consider what needs to be **told** and what can be **discovered** (including potential benefits or drawbacks to each method for that person at that moment). While Socratic dialogue is considered one of the cornerstones of cognitive therapy (e.g. Kazantzis *et al*., 2018), there is still little direct evidence and, to our knowledge, no experimental studies to support its effectiveness (e.g. Clark and Egan, 2015; Farmer *et al*., 2017; Harrison *et al*., 2019; Vittorio *et al*., 2021), although it is perceived to be more helpful, empathic and autonomy supporting in an experimental study with non-client observers (Heiniger *et al*., 2018).

How you might explain this to people with OCD and family members

People with OCD often experience thoughts, images, doubts or impulses that they then interpret as meaning something significant. These types of thoughts are unpleasant and distressing to the individual and can appear to pop up out of nowhere. These 'intrusive thoughts' often lead to distressing emotions in people who experience them, especially feelings of anxiety, fear, shame and guilt. The individual then feels they must do something to control, get rid of, or counteract these thoughts, which is also worsened by the negative emotions they are feeling. We call the actions that people take 'safety-seeking behaviours'.

For example, a person with OCD may have the intrusive thoughts 'my hands are covered in dangerous germs, I'm going to be seriously ill or make my loved ones ill', which causes them to fear for their health or potentially the health of those around them, feel responsible, and then experience anxiety and guilt. This person may then wash their hands repeatedly until they feel their hands are completely clean and the germs no longer pose a threat.

Attempts to counteract intrusive thoughts (usually to prevent 'bad things' happening) to avoid or reduce the distress that they can cause are sometimes called 'neutralising'. These safety-seeking behaviours can be visible to others, such as frequently checking the oven to make sure it is switched off, or they can be thought processes that are not observable to others around them, such as mentally visualising the checking, or replacing the intrusive thoughts with other less distressing thoughts (e.g. the oven switched off), or simply keeping oneself busy to provide distraction from the intrusive thoughts. Although intrusive thoughts are normal and experienced by almost everyone, the attempted solution actually becomes part of the problem as the number, frequency and duration of safety-seeking behaviours increases.

Top tips

- Developing a shared understanding in everyday words (avoiding jargon) for the person helps normalise the experience. If you start to use terms such as safety-seeking behaviours or intrusive thoughts, check that the person has a shared understanding of these.
- It is important that the person with OCD and their family understand that intrusive thoughts, images and impulses are experienced by almost everyone and are indeed part of the normal experience of life.
- People can feel a sense of shame or that no one else has ever had the thoughts and behaviours they are experiencing; help them to understand that you have heard similar thoughts before and that these are typical of OCD, and indeed experienced by people who do not have OCD. Consider sharing sources of reputable information to reinforce this message (e.g. De Silva and Rachman, 1998, or 'What are obsessions?', OCD-UK, 2021).

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- Be curious about how the person makes sense of their thoughts, try and understand the logic connecting the meanings they make of the intrusive thoughts, their feelings and subsequent behaviours. Help them understand that their behaviours make sense in the context of their beliefs.
- Acknowledge the distress and difficulties it is causing in their life and use this to build motivation to change.
- Acknowledging as early as possible in treatment that doubt is usually an integral part of OCD can help people better to understand their experience and the pull of additional behaviours to try and remove doubt and uncertainty (Samuels *et al.*, 2017).

Once a shared understanding of a CBT model of OCD has been developed, it is then important to focus on how the compulsions, safety-seeking behaviours, neutralising, etc., maintain the problem for that individual. Although safety-seeking behaviours and neutralisation reduce the anxiety that people with OCD experience in the short term, this anxiety and distress recurs in the long term alongside the urge to use further safety-seeking behaviours (Salkovskis and Kobori, 2015). Literature suggests that this short-term anxiety reduction and temporary respite from negative intrusive thoughts acts as a form of negative reinforcement which helps to maintain safety-seeking behaviours (Abramowitz *et al.*, 2009; Veale and Roberts, 2014). The use of safety-seeking behaviours also stops individuals from being able to understand that their intrusive thoughts do not have the feared meaning that the OCD might suggest and so is ultimately counterproductive by contributing to the perpetuation of OCD symptoms through a vicious cycle (Haciomeroglu, 2020; Haciomeroglu and Inozu, 2019). This explanation is supported by empirical studies which have found those with OCD who use safety-seeking behaviours (such as reassurance seeking) more intensely, also report feeling more anxious and less reassured than those who use such safety-seeking behaviours less diligently (e.g. Salkovskis and Kobori, 2015).

Some strategies have a clear functional link (Ladouceur *et al.*, 2000) between the thought and the behaviour (e.g. having a thought that you have left the oven on, the house will burn down, and you will be held responsible, so check the oven) but some may have no obvious link. In many cases rules may develop about what behaviours to do, how to do it and when to stop (Bouvard *et al.*, 2020; Bucarelli and Purdon, 2015; Salkovskis, 1999; Wahl *et al.*, 2008). While the behaviours may take a wide range of forms, it is important to understand the function of the behaviour rather than being focused on its specific form (Thwaites and Freeston, 2005). This is particularly important because according to specific details of the situation, mood state, presence or absence of others, the person with OCD can draw on a repertoire of strategies and substitute one for another (Freeston and Ladouceur, 1997). Safety-seeking behaviours can also serve multiple functions for the individual, therefore understanding these functions leads to a better comprehension of the relationship between intrusive thoughts and safety-seeking behaviours (Starcevic *et al.*, 2011). An example of how safety-seeking behaviours maintain the problem is detailed below, which can be used by therapists to help people with OCD and their family to understand this concept.

How you might explain this to people with OCD and family members

Although safety-seeking behaviours give the person relief in the short term, they actually end up reinforcing these distressing thoughts and behaviours and making them more likely to occur in the long term. When the same or similar intrusive thoughts come back in the future, they seem even more important and the person feels they have to try to control, get rid of, or neutralise them even harder than before. They can also end up with people with OCD needing those around them to continue to act in specific ways to help them deal with the intrusive thoughts.

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People with OCD may develop rules over time about what safety-seeking behaviours they can use, how often and when is safe to stop. For example, if a person has intrusive thoughts about germs, they may believe they have to wash their hands for at least three minutes in order for them to be clean. However, these rules and rituals can become more elaborate and time consuming with time; for example the person may then start washing their hands with soap for at least five minutes to feel properly clean which may increase to ten minutes a month later, or lead them to add in extra steps such as using a strong cleaning agent.

The safety-seeking behaviours people use can also sometimes be transferred from the initial situation, for example in the previous case the person may also wash the things they come into contact with, such as door handles, work surfaces and computer keyboards, thoroughly before and after using them to avoid contamination. The more frequently people with OCD use safety-seeking behaviours, the more important, frequent and distressing the intrusive thoughts may become. This increased emphasis on their intrusive thoughts leads people to try increasingly harder and for increasingly longer periods of time to control, neutralise or get rid of these thoughts, often wearing themselves out.

Top tips

- Once you have a clear understanding of the feared outcome, imagine you share that belief then imagine the range of behaviours that you might perform to prevent this from happening. Follow the internal logic (discussed in detail in the following section) and check your understanding with the person using summaries and seeking feedback.
- Many people will not be aware of the behaviours they are performing as part of the OCD, potentially because they may have been doing them for so long that they do not notice them or now just follow a set of rules or do them ahead of experiencing the anxiety (pre-emptively) like a habit. They may even have forgotten *why* they do them.
- When a person manages to reduce a specific behaviour, always be alert to the possibility that they may have inadvertently engaged in other behaviours to prevent the outcome, e.g. replaced one safety-seeking behaviour with a different one, often an invisible one, to achieve the same outcome.
- Consider subtle ways that the individual may achieve a reduction in anxiety; sometimes it can be by what their loved one does *not* do or say in response to a situation ('reassurance by omission'), e.g. telling a loved one that you have closed the front door and not checked it (with the lack of response by the loved one acting as reassurance that this is fine and also with implicit sharing of responsibility).

Insight and internal *vs* external logic

OCD can only be understood within the context of the individual's background and own personal beliefs and culture. Therapists need to adopt a multicultural perspective, being aware of how OCD may present differently within different cultures and acknowledging their own biases and assumptions about other groups. Behaviours that may be viewed as 'abnormal' from a white Western perspective might make complete sense in the context, for example, of an individual's personal experience of racial discrimination or their own specific religious or spiritual beliefs (for a detailed discussion, see Williams *et al.*, 2020).

Relating to the concept of internal *versus* external logic, the question of insight has always been a key point of discussion and indeed in the definition of OCD (for a conceptual analysis of insight in OCD, see Marková *et al.*, 2009). Good insight was previously used as a criterion for OCD in the *DSM-III* (American Psychiatric Association, 1987), and was viewed as inherent to the diagnosis of

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OCD. Since then, clinical observations and studies have led to wider acceptance of the idea that people with OCD can have poor insight into their obsessions and compulsions (e.g. Catapano *et al.*, 2010; Kozak and Foa, 1994; Matsunaga *et al.*, 2002). Insight is now included as a specifier, not a criterion, for OCD under *DSM-5*, ranging from 'good or fair insight' to 'poor insight' to 'absent insight/delusional beliefs' (American Psychiatric Association, 2013). However, it has been suggested that insight should be reconceptualised as a mental state, in contrast to the traditional view that insight is a symptom of OCD or a constituent feature of OCD symptoms (Marková *et al.*, 2009). This reconceptualisation is based on studies and clinical observations which have found that individuals with OCD can fluctuate between having good or poor insight into their OCD over time (e.g. Abramowitz and Jacoby, 2015; Landmann *et al.*, 2019). Recent studies have suggested that the perspective people take about their OCD is highly situation-bound. Indeed, Landmann *et al.* (2019) used a time sampling method 10 times a day over 6 days and found a substantial fluctuation in insight over time among individuals with OCD. Some authors describe how individuals may be open to questioning or even perhaps rejecting their beliefs about their obsessions and compulsions when in a safe environment, but when faced with triggers they become convinced of the 'truth' of their intrusive thoughts and the need for their safety-seeking behaviours (O'Dwyer and Marks, 2000). Other authors propose that perceptual or sensory experiences related to obsessions and compulsions contribute to the sense that they are real (e.g. Moritz *et al.*, 2017). Studies suggest that these fluctuations may be related to anxiety levels, as those with poorer insight are found to have significantly higher anxiety levels than those with good insight (Türksoy *et al.*, 2002). An alternative way of thinking about insight is the 'inside' perspective, i.e. the internal logic of an obsessional cycle, *versus* the ability to take an 'outside' perspective. The difference between these perspectives can be a source of misunderstanding and confusion for both therapists and family members of those with OCD, but a simple way of explaining this is provided below.

How you might explain this to people with OCD and family members

A challenge for many people around those with OCD is to understand that OCD looks different to people from the 'inside' compared with looking at it from the 'outside'. From the 'inside' of OCD there is an internal logic to what people are doing, which makes sense to them. From this perspective, people are facing a really important situation or dilemma and are desperately trying to do the right thing. However, from the 'outside' of OCD the situation may not be seen as really important. Therefore, the behaviours of people with OCD can seem irrational, absurd and 'over the top', because for people on the 'outside' it is not apparent why the reaction of the person with OCD is the 'right' thing to do. Many family members and others, including therapists, are on the 'outside' and can perceive these safety-seeking behaviours in different ways. For example, they may find them confusing and irritating, or label them as manipulative or attention seeking, although from the 'inside' they are none of these things. Often people on the 'inside' of OCD view the situation as a matter of life or death, or as though their whole self or the people they love most are in danger in an extreme way. If the loved ones of people on the 'inside' of OCD cannot understand this reasoning or cannot respond 'in the right way', this can be really upsetting for the person on the 'inside'. This mismatch between viewpoints leads to people on both sides feeling tense, frustrated and misunderstood, and may lead to distress or conflict.

Nonetheless, many people with OCD can switch between having an 'inside' or an 'outside' perspective on their behaviour, adding to their own distress. For instance, when people with OCD feel relaxed, are in a safe place and are not faced with any triggers, they may take the 'outside' perspective, thinking 'it makes no sense that I need to check the oven is switched off so many times, I just need to stop doing it and I will'. Yet, when they are faced with the trigger or

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feel distressed, they may revert to the 'inside' perspective and start to believe more that 'it makes complete sense that I need to check the oven is switched off seven times, I must do it, otherwise the house will catch on fire and everything and everyone inside will go up in flames'. It has also been suggested that people with OCD may sometimes occupy the 'inside' and 'outside' perspectives at the same time, leading to a state of doubt or confusion.

Working with the evolution of the intrusive thoughts and safety-seeking behaviours

Although there is often relative stability of the *presence* of obsessions and compulsions over time, the actual *content* of the obsessions or the behaviours may evolve. One possible pattern is that the content moves from one area of concern to another, for example from germs to environmental contaminants. Alternatively, within the same basic topic, the specifics may evolve, either spreading from a specific threat to wider versions of the same threat (e.g. from concerns about the oven, to concerns about all electrical appliances, and then to light switches, etc.) or the threshold of what is potentially dangerous reduces (e.g. from initial concerns about large kitchen knives, to smaller knives, blunter table knives, and then to any pointed object like a pencil). In a similar way the different behaviours that a person uses can also evolve, as people add in new or additional strategies (e.g. adding mental checks to physical checks), or new rules about the strategy (e.g. how many times, when to stop, etc.) in order to maintain or increase the perceived effectiveness. Finally, the relationship between the thoughts and the behaviours may also change so that behaviours become triggered by an activity (e.g. getting ready to leave the house) or contextual cues (e.g. being in an area that 'looks dirty') rather than the actual occurrence of thoughts. At the limit, it may seem that the person does not report any current obsessions. The text below is an example of how a specific instance of obsessions and compulsions may evolve over time; this can obviously be adapted to refer to the specific intrusive thoughts and behaviours of the individual instead. The evolution or escalation can increase the impact and interference on day-to-day living, but also make the symptoms more puzzling from an 'outside' perspective.

How you might explain this to people with OCD and family members

Over time the associations between the occurrence of an intrusive thought and neutralising behaviour as a response can become weakened or lost. For example, a person with OCD may have previously had intrusive thoughts such as 'I might lose control and do something terrible like attack someone'. People can begin to respond to triggers (e.g. planning to go out) with compulsions (e.g. repeat to themselves that they are a good person) rather than wait for intrusive thoughts to happen, do things 'just in case' they have intrusive thoughts (e.g. make sure they are not carrying anything sharp or heavy with them), and attempt to prevent intrusive thoughts happening by building up enough 'protection' through safety behaviours in advance (e.g. if they are religious, to pray or read religious texts and then carrying a religious book or object with them). All of these may be used even before the person has had the intrusive thought or they can spread to other situations or triggers over time (e.g. when someone comes to the house) because if the first situation is possible, then the other situation may also be possible.

Individuals with OCD can also begin to attempt to arrange their life and environment so that they won't encounter triggers, which sometimes leads them to give up things that are important to them in order to do so. They may start making sure they have someone they trust with them when they leave the house who will be able to stop them if they start to lose control. These thoughts could lead them to not leave the house if other people are unavailable to go with them, potentially missing out on things like social events, sports or hobbies because the thought of having to get there by

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themselves causes them too much anxiety about losing control. This also means that family members may have to give up activities in order to accompany them.

The specific rules people with OCD develop about their safety-seeking behaviours can become so established that the rules begin to drive the use of these behaviours rather than the presence of triggers or intrusive thoughts. These rules can develop into a routine structuring how a person lives their entire life; if they don't complete their routine this is distressing, so the routine becomes compulsory for them. Sometimes people can find their routines comforting on one level but frustrating, exhausting and anxiety provoking at another. All of these things can make the safety-seeking behaviours so much harder for people on the 'outside' of OCD to understand as the behaviours become more confusing and appear less rational or more excessive from this perspective.

Top tips

- Although we have provided examples of how this might be explained to a person with OCD and their family, obviously it is crucial to understand their language and adapt yours to ensure it matches, always checking out their understanding. It is important to answer any questions – what might be obvious to us seeing the third person that day with OCD might be very new information to someone engaged in CBT having just found out they may have OCD for the first time and may take some adjusting to.
- Repeated questions may be seeking reassurance rather than better understanding, so be aware of this possibility and be ready to explore this possibility with the person.
- Whenever possible, individualise the explanation using their own thoughts, emotions and behaviours and contextualise this within their own specific culture. Don't make assumptions on the meaning of behaviours – ask. (The therapist should be asking more questions than the client!)
- Whilst the explanation can provide a logical rationale for the behaviours they have engaged in, it is important to also pay attention to, and validate, both the emotional impact and the consequences of the OCD. Many people have lost a lot due to their OCD, from relationships to education, jobs, roles, and a whole range of missed life opportunities.
- According to age of onset and duration, OCD may have fundamentally changed their life trajectory. Anger or grief are common, and people may have to readjust to the possibility of life without OCD, and may need to catch up on life tasks that have been compromised or lost.

How do family members become involved in neutralising and avoidance?

It is very common for family members (and also therapists) to become entangled in people's safety-seeking behaviours (Albert *et al.*, 2017), and this is often motivated by their desire to lessen the person's distress, functional impairment and decrease their compulsions (Storch *et al.*, 2010). Many people, including family members, become involved in neutralising and avoidance behaviours simply because they care. However, family members can sometimes be perceived as unhelpfully contributing to, or maintaining, the problem and the authors have seen this being labelled unhelpfully by mental health staff using such terms as 'collusion' and 'secondary gain'. These terms have negative connotations surrounding them and do not capture or reflect the complexity of why they occur. However, there is some evidence that other's behavioural involvement at the start of treatment can be associated with poorer treatment outcomes (e.g. Yanagisawa *et al.*, 2015). This phenomenon is also called accommodation in the literature and can be assessed using the Family Accommodation Scale (FAS). While initially developed as an interview measure (Calvocoressi *et al.*, 1999), self-report

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versions of the FAS exist which can be completed by both people with OCD (Pinto *et al.*, 2013; Wu *et al.*, 2016) and their family members (Flessner *et al.*, 2011). Interestingly, the FAS has also been adapted for use in other languages including Spanish (Otero and Rivas, 2007), Hindi (Mahapatra *et al.*, 2017), Chinese (Liao *et al.*, 2021) and Japanese (Kobayashi *et al.*, 2017), all suggesting that the involvement of family members in OCD behaviour is a robust cross-cultural phenomenon, although the number of items and exact factors vary from one study to another. Research suggests that the specific role of the family of people with OCD may differ according to culture and it has been suggested that 'Interpersonal difficulties and associated enmeshment from OCD difficulties may be particularly harmful in collectivistic cultures and necessitate additional consideration by clinicians' (Williams *et al.*, 2020; p. 13). Therapists need to consider and ask about family and cultural traditions and take this into account when understanding the role of family members and involving them in the treatment.

On the other hand, individualistic beliefs and values are common in Western developed countries and research suggests these values are increasing globally (Santos *et al.*, 2017), which may impact the involvement of family in therapy. For example, Breunlin and Jacobsen (2014) suggested in individualistic societies if parents seek therapy for their child, they tend to favour individual therapy as a default because they generally think of the child's individual needs first. They also suggested people living within individualistic cultures can sometimes prefer not to talk to their family or those around them about their mental health issues and, because of their beliefs about what is best for their loved ones, family members often are happy to avoid these difficult conversations. Therefore, as individualism is often in conflict with family members coming together to discuss the needs of the family as a whole or an individual within it, this can be a barrier that needs to be considered in terms of family involvement in therapy (Breunlin and Jacobsen, 2014).

The literature supports the various ways that family members may be involved and implicitly the varying motivations to do so. It must also be remembered that people with OCD may actively seek the involvement of others as recent studies have suggested that compulsions can be conducted with an 'audience' in mind and showing that they are not responsible for harm can be an important motivation once a compulsion starts (Dean and Purdon, 2021). In summary, studies suggest that many family members show some level of involvement in the safety-seeking behaviours of people with OCD, with the most common ways being: providing reassurance, engaging in safety-seeking behaviours, and helping with avoidance of anxiety inducing stimuli (Albert *et al.*, 2017).

How you might explain this to people with OCD and family members

Other people often get caught up in these safety-seeking behaviours simply because they care. People can see the distress OCD causes their loved one and respond to it because they want to help make them feel better. Family may prefer to help out with safety-seeking behaviours because they would rather the person with OCD spends less time on them, freeing them up to spend more time on the things in their life that are more important, such as school, work and achieving their life goals. Family members may also want to help the person get past their OCD so that they can get on with their life and may be attempting to help the person to combat their difficulties. People may also get involved because they want to buffer the impact the OCD has on other family members. Furthermore, people may feel a duty of care for the person with OCD, guilty that they cannot fix the OCD themselves, or simply overwhelmed and distressed and can't think of an alternative to help the person with OCD other than helping them to complete safety-seeking behaviours. All these intentions are completely understandable and blameless as family members hope to help the person, and others around them, to cope with the OCD.

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Many people can get caught up in neutralising behaviours, whether they know it or not, including friends, family members, colleagues and sometimes therapists. It is important to emphasise that there is an almost unlimited array of possible neutralising behaviours people with OCD can use to provide relief, and it is the function of the behaviour that is important (i.e. what it is aiming to achieve) not the form it takes (i.e. what it looks like). All these neutralising behaviours are trying to do the same thing, meaning that they have similar functions and so can be substituted for each other. The OCD can be 'sneaky' in the way it maintains itself through neutralising behaviours because it works using the 'inside' logic and it can be very creative in coming up with new neutralising behaviours when one is blocked. The situation or intrusive thoughts are interpreted as extremely vital to people with OCD, so behaviours that must be completed but may appear 'weird' to others, or are perceived as not socially acceptable, or are unable to be carried out in specific situations, may then be forced 'underground' by using substitution or delaying until later when no-one can see them.

For example, if someone experiences reoccurring intrusive thoughts such as 'I haven't locked the front door, I am going to be robbed of everything I own', if they feel it would be hard to carry out the checking or that they would be judged badly for openly going back to check if the door is properly locked, they may simply replace this safety-seeking behaviour with another. For instance, they may mentally check if they can visualise themselves locking the door when they left, ask someone else whether they remember them locking the door, ask someone else to lock the door, or simply leave early forcing someone else to lock the door, which transfers the responsibility to someone else, sometimes without them even realising.

It is important that during therapy we recognise that when others are involved in the neutralising and avoidance systems of OCD this is ***ultimately*** *unhelpful, so therapy should aim to carefully disentangle family members' caring intentions from involvement with OCD. However, because of the complex interpersonal nature of this entanglement, it is important to proceed cautiously. Only when the person with OCD is in agreement and ready should family members be asked to change their behaviour.*

What can family members do instead?

People with OCD need to look after and support themselves during therapy to begin the hard task of doing the things they find difficult, keeping going and picking themselves up again when they get knocked back. However, they also need to have help and support more generally from those around them. For individuals with mental health issues, family members are often a crucial source of support (Kobori *et al.*, 2017). Recent research and theory suggest there are a number of subtle differences between effective and counterproductive support that family members can try to give people with OCD. During exposure or behavioural experiments, family members can provide support in a number of ways, which could include providing words of encouragement, support or a hug, or simply acknowledging how difficult this is, rather than becoming involved in safety-seeking behaviours. Research suggests when people with OCD receive supportive feedback from their partner following an exposure task this can increase perceived helpfulness of the feedback given and reduce reassurance seeking behaviours compared with those whose partners were instructed to provide neutral or more generally supportive responses to reassurance seeking (Neal and Radomsky, 2019). Literature also suggests that people find this approach to treatment more acceptable than traditional CBT, which focused more on reducing accommodation to requests for reassurance (Neal and Radomsky, 2020). Dependent upon the individual's culture and beliefs, it may also be important to involve other individuals from the person's community, e.g. traditional healers or religious leaders.

Additionally, approach-supporting behaviours can be used during therapy to help people with OCD move closer to situations that provoke their anxiety, allowing them to learn new information

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which can help them challenge their maladaptive beliefs (Salkovskis and Millar, 2016). The idea of using supportive aids or behaviours to help during therapy is not a novel concept. Indeed, Bandura and colleagues (1974) found people with snake phobia who used moderate to high levels of supportive aids during therapy achieved greater changes in behaviour and anxiety beliefs than those with minimal use of supportive aids. More recently, studies have found the use of approach-supporting behaviours, including wearing protective clothing or using hygienic wipes, during exposure and response prevention therapy can help to reduce contamination-related obsessions and fears among university students (Levy and Radomsky, 2016; Rachman *et al*., 2011). Additionally, research has found that using supportive aids can help individuals to engage in greater approaching behaviours towards their phobic objects, which may help them to learn new information (Milosevic and Radomsky, 2008; Milosevic and Radomsky, 2013). During exposure and response prevention, family members can also act as supportive aids, helping to lower their loved one's anxiety in order to help them get closer to their feared situations. Moreover, some experts suggest that this approach has the potential to reduce drop-out rates and treatment refusal (Rachman *et al*., 2008).

The intention behind using approach-supporting behaviours (ASBs) is to allow people to move closer towards their anxiety-provoking situation in order to explore the situation and gain new information that can disconfirm their intrusive thoughts (Salkovskis and Millar, 2016). In contrast, the intention behind safety-seeking behaviours (SSBs) is to find safety from perceived harm. The distinction is important but can be subtle and it is important to be able to work out which is which and have a shared understanding with the person with OCD and those around them.

Whilst we are not aware of studies looking at ASBs in OCD, we can make some informed clinical predictions based on how ASBs function in other anxiety disorders (e.g. Milosevic and Radomsky, 2008). There are several dimensions to consider, namely, the topography or form of the behaviour (i.e. what it looks like), the intention, and short- and long-term consequences. As can be seen in Table 1, with the exception of avoidance, the behaviour may appear identical. The critical distinction is in the intention: while SSBs always seek to reduce threat, responsibility, distress regarding uncertainty and thereby increase safety, ASBs will seek to partially and temporarily reduce these factors in the pursuit of learning. Simply put, if the situation is avoided, nothing can be learned. ASBs may allow engagement and learning, but on the understanding that these are temporary measures. It is also important to emphasise that these behaviours are not substitutes that may cause less interference in a person's life than existing behaviours, but an active and temporary choice to facilitate engagement. Table 1 provides an initial guide to help clinicians distinguish between SSBs and ASBs, and reflects our current level of understanding, although more research is required to confirm this. For example, future research in this area could empirically test out the impact of ASBs in OCD, as Milosevic and Radomsky (2008) did for snake phobias. This study could be adapted to investigate the key questions of whether ASBs increase what people with OCD are able to do in terms of approaching and staying in threat situations, and whether it impairs their learning from exposure. An earlier potential step could be a single case experimental design or case series examining the role that the use of ASBs plays in facilitating approach to feared scenarios and whether they impair changes in cognition. This research would have the benefit of being able to ensure clinical validity by using individualised threat situations and ASBs.

There are good theoretical and empirical reasons that ASBs used with the intentions described above should lead to both short- and long-term consequences that are different from those associated with SSBs. The short-term consequences will allow capture of relevant information. While this may sometimes lead to an 'aha' moment, in many cases it will provide new information that needs to be reviewed, made sense of, and then followed up with more of the same, new experiments, or a decision to drop the ASBs and also the SSBs as well. In the longer term, as more new information is captured, the unhelpful appraisal of the intrusive

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Table 1. Mapping out a conceptual framework to distinguish between safety-seeking behaviours and approach-supporting behaviours

Criteria	Safety-seeking behaviours	Approach-supporting behaviours
Topography		
Cognitive/covert	Sometimes	Sometimes
Behavioural/covert	Sometimes	Sometimes
Behavioural/overt	Sometimes	Sometimes
Use of props/aids	Sometimes	Sometimes
Interpersonal – reassurance	Sometimes	Sometimes
Interpersonal – information seeking	Sometimes	Sometimes
Avoidance	Sometimes	Never
Intention		
To reduce current (perceived) threat	Always	Sometimes*
To prevent future threat	Always	Sometimes*
To reduce (transfer) responsibility	Always	Sometimes*
To reduce distress	Always	Sometimes*
To reduce uncertainty	Always	Sometimes*
To facilitate new learning	Never	Always *Partially, to permit engagement and so learning
Short-term consequence		
Escape/avoidance of perceived threat	Reduced threat	Capture relevant information about threat
Reduction of perceived responsibility	Reduced responsibility	Capture relevant information about responsibility
Escape/avoidance of emotional distress	Reduced distress	Capture relevant information about distress tolerability
Tolerate uncertainty	Reduced uncertainty	Capture relevant information about uncertainty tolerability
Learning – 'Theory A'	Near miss . . . (SSB saved me)	New information: 'Theory A' challenged
Long-term consequence		
Beliefs about perceived threat	Maintains perception of threat	More realistic perception of threat
Beliefs about perceived responsibility	Maintains perception of responsibility	More realistic perception of responsibility
Beliefs about of emotional distress	Maintains perception of distress intolerance	More realistic perception of tolerability of distress
Beliefs about uncertainty	Maintains intolerance of uncertainty	Greater tolerance of uncertainty
Learning – 'Theory B'	None	Learning occurs; 'Theory B' supported
Repertoire of safety behaviours	Remains intact or may increase/ escalate	Will reduce
Interference in everyday life	Remains	Reduces as need to rely on SSBs decreases

thought is increasingly challenged, and importantly the non-threat appraisal gathers more and more support. Perceptions become more realistic and the range of SSBs reduces, leading to more stable perceptions, but also decreases in interference. It is important to remember that the best predictor of long-term stability is low levels of symptoms (i.e. behaviours) at the end of treatment (e.g. Eisen *et al.*, 2014). When the temporary reliance on ASBs has gone, then the reliance on SSBs must also be addressed.

How you might explain this to people with OCD and family members

To fully engage with treatment and progress towards recovery, people with OCD need to do things that they will find hard. For example, if a person has the intrusive thoughts that bad things will happen to their family members if their books aren't organised in a specific way (leading to anxiety and attempts

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to ensure the books on their bookshelf are in a particular order), this person will have to confront situations in which their books are not organised in the way that meets their criteria.

Whilst it is important for people with OCD to take responsibility for addressing these situations and behaviours, they need support to do this due to the high levels of anxiety and distress that changes in behaviour may cause. Rather than becoming involved and participating in avoidance, safety-seeking behaviours or neutralising, it is more helpful if family members provide emotional support or use approach-supporting behaviours (for example, telling the person with OCD that they care about them and are there for them whilst they address these difficult situations).

People with OCD, their family and other supporters or carers need to work together to support the individual with OCD effectively. There are four main ways to go about this. Firstly, they need to distinguish between when family members are providing support and when they are getting involved in safety-seeking behaviours. Secondly, they need to agree amongst themselves how to best provide the individual with general support and support to face their OCD through approach-supporting behaviours. Thirdly, it is important that family members agree and make sure to continue giving the individual general support regardless of what happens. Fourthly, the individual and their family members should agree when and how to reduce or remove the involvement of family members in OCD safety-seeking behaviours. Only when this agreement is reached should the family members reduce their involvement while continuing to provide emotional support in the agreed way.

For instance, using the above case, the individual and their family members may decide that family members should gradually reduce the number of times they organise the books on the bookshelf so that they are in the 'correct' order over the space of a month until they no longer do so. Then once family members are no longer involved in that safety-seeking behaviour, they will repeat this by gradually reducing the amount they reorganise the tins of food in the cupboard for another month until they are no longer involved in these compulsions. It is good for family members and the individual with OCD to decide what will happen if their plan does not work first time round, which may involve going back to the beginning of the plan and starting again or modifying the plan informed by the difficulties encountered the first time.

An example of how to introduce approach-supporting behaviours is provided below.

How you might explain this to people with OCD and family members

There are several subtle features of approach-supporting behaviours that can make a huge difference to recovery. If you think about it in terms of teaching someone how to swim, there are two different philosophies you could take:

(1) *Either you could throw the person in at the deep end and they might eventually figure out how to swim. If they do not succeed at first, you would step in and stop them from drowning. But, once they have recovered, you will try again.*
(2) *Or you could start in the shallow end and go into the water with the person and stay close by, you give the person arm bands and/or a float and once they feel comfortable, they can float away a bit and then come back. Once they feel more comfortable, they won't need you in the water anymore. When they can keep themselves afloat you can deflate their arm bands a bit or get rid of the float so they can move around and use their arms more. Then when they feel comfortable you can get rid of the arm bands and then they are able to swim for themselves. When they can swim for themselves, the supporter can stay on dry land. And eventually the person can go swimming by themselves and can simply report back on the enjoyment they had while swimming.*

The second philosophy is an example of approach-supporting behaviours which provide the individual with more support to tackle the things that are difficult to them. Approach-supporting behaviours might for example include giving the individual with OCD encouragement

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or a hug, saying 'I know this is difficult for you, I am here for you while you confront this', and waiting in the background while they conduct the task. Then afterwards, they can listen to the person talk about their experience, and regardless of the outcome, recognise the courage in the attempt. Approach-supporting behaviours like these can help the person to address their OCD, without family members doing it for them, whilst recognising the effort it takes them to do this instead of the outcome. Whether they succeed or fail, the support will be there when they next attempt to confront their OCD.

Family members and other important people in a person's life are not able to confront the OCD for the person, the person with OCD can only do it for themselves. However, additional supports can be useful to help make starting easier and to help the person get going, but these are only temporary. These additional supports will help the individual to go into the situations that usually cause them anxiety and distress or may be avoided, allowing them to learn what they need to, helping them to challenge the meaning that they give to intrusive thoughts or the triggering situation. By supporting people with OCD to go into these challenging situations, therapists and family members will be helping them to gradually increase their skill and confidence, which will mean the additional supports can be removed bit by bit when the time is right. Gradually as the individual's skills and confidence progress further they will need their family members support less and less as they face their challenges, until eventually they no longer need any support as they will be able to do this by themselves.

For example, a person may go through their house each night before bed, repeatedly checking that all the doors and windows are locked and all the plug sockets are switched off because of intrusive thoughts they have about bad things happening whilst they sleep. To tackle this, they may agree with their family and therapist to begin by not checking the plug sockets upstairs before they go to bed. Some approach-supporting behaviours address the anxiety people may experience. So, with the support of their family, they may be encouraged to use relaxing sounds and techniques to help deal with their anxiety and make falling asleep easier. Then when they are confident nothing bad has happened because they did not check those plug sockets and were able to fall asleep without becoming anxious, they may add not checking the plug sockets downstairs. Other approach-supporting behaviours may be the family member offering encouragement and a hug as they resist the urge to check. Of course, it is important to make sure that providing support is not also permitting a transfer of responsibility, for example, if the person providing support is in the same room and has inadvertently provided reassurance by their presence alone. As they progress and become more confident, they may begin to add not checking the upstairs windows are locked, then when the time is right moving on to add not checking the downstairs windows and eventually not checking the door is locked, whilst still using these supports. Eventually, they will not need their family members to offer so much support when they do not perform their checks and when it is appropriate, they will gradually reduce their use of relaxation techniques to help calm them down to sleep. Finally, they will be able to stop using their techniques to help them to sleep as they will be able to get to sleep by themselves without completing their checks or using their supports.

Top tips

- Once the difference between safety-seeking behaviours and approach-supporting behaviours is established, encourage the person and their family members to creatively identify current approach-supporting behaviours (that can be increased or built up) or generate new ones that would support the person in facing their fears.
- Always check out their beliefs and understanding about the impact of the approach-supporting behaviours both in the moment but also in the longer term.
- Be clear that approach-supporting behaviours are a temporary solution and work towards dropping these before the end of therapy and be mindful that sometimes ASBs could become SSBs.

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- When planning discharge, check that the person and family still understand the difference between approach-supporting behaviours and safety-seeking behaviours and can identify potential future examples.
- Family members can also be key in helping the person with OCD to engage further with life and what is important to the person, rather than with the OCD, as part of the task of reclaiming the parts of their lives that may have been lost.

The 'special' case of reassurance seeking

Reassurance seeking in OCD has been the topic of much discussion in CBT. Sometimes it is seen as merely a functional equivalent to other safety-seeking behaviours, so it is not really 'special'. For example, people can get the answer they need by checking things for themselves or they can ask others to check and provide them with this reassurance. However, on another level, reassurance seeking is sometimes seen as a special case as it often involves interactions between people which frequently function on many different levels, often at the same time, especially between people who are close to each other. When someone is providing reassurance to their loved one, they are in the role of reassurer but potentially also as parent, partner, lover or friend at the same time, and it can be hard to disentangle these and the various implications (therapists are also not immune from falling into providing reassurance). Regardless of whether reassurance seeking is a special case or not, it can be a specific and often challenging issue to address in therapy. The text below provides an example of how you might start to explain this.

How you might explain this to people with OCD and family members

Reassurance seeking can look very different in different situations and the same reassurance-seeking behaviour can mean different things. For example, if someone experiences frequent intrusive violent thoughts of hurting those around them, they may seek reassurance from family members and friends that they are actually a good person. This may lead them to ask their partner direct questions out of fear and guilt such as 'Do you think I am a good person?'. Or they may indirectly seek the same reassurance by checking the facial expressions of family members to make sure they haven't done anything wrong or upset anyone.

In different situations, perhaps when feeling helpless and stuck, asking 'Do you think I am a good person?' could mean 'Please help me this is really difficult and I am really struggling, I am trying to do the right thing, but I need your support', or 'Just tell me I am not an awful person'. Sometimes in moments of frustration it could also mean 'This is the only way I can see this, why can't you see it my way?' or even anger, with 'If you just answer my question, we can get on with the rest of the day, why won't you?'.

On the other hand, providing reassurance can also mean different things. For example, if the individual's partner responded to their question by saying 'Of course you are a good person' this can mean different things. For instance, a bewildered partner may mean 'I know I shouldn't do this, but I don't know what else to do', or 'I don't understand why I need to say this'. A resigned partner may be saying 'Here we go again'. Or 'I will feel awful if I don't help them to feel better' accompanied by guilt. Or a frustrated but pragmatic family member may even be saying 'If I don't tell them they are a good person we won't be able to move on and will be stuck on this subject for ages'.

So, it is not just the words themselves, it is also the context, the emotions, the frequency and the tone of voice that add layers to the interaction between the person seeking and the person providing reassurance. It is these added layers that make reassurance seeking a special case as this affects not only this specific exchange but can spill over and affect other aspects of the relationship.

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The key to overcoming reassurance seeking is to make it clear what is happening when the person with OCD seeks reassurance and their family provides it, and then separating the valuable parts like care, support and encouragement from the OCD-driven behaviour, so that they can eventually become disentangled. Thinking about how to best provide support when people with OCD ask for reassurance is important. This could involve, for example, by sharing the mutual distress the situation causes each other or by emphasising the support and encouragement and working together to turn what may be unhelpful interactions into a valuable source of support. From this point people can work together and get on the path to beat OCD. It is important to emphasise that it is the responsibility of the individual with OCD to decide and communicate what behaviours should be changed and when (rather than this being imposed on them by those around them).

Summary

This paper has provided specific guidance on how current treatment models of CBT can be developed and implemented when family members or loved ones need to be involved in treatment. It has also made the person-centred distinction between understanding the OCD from the inside versus from the outside which can be easily explained in practice.

The latter part of the paper has started to operationalise the relatively new concept of approach-supporting behaviours in OCD and provide some guidance (adapted from research in other areas and combined with extensive clinical observation) on how to distinguish approach-supporting behaviours from safety-seeking behaviours. We emphasise that this is not based on the form of the behaviour alone, it is more subtle than that and requires an understanding by all of the intention. Further research is required to confirm the initial framework outlined in this paper.

The ideas within this paper would suggest that training and supervision of therapists working with OCD needs to include discussion and skills practice around working with the family when they are involved. This will support effective implementation of CBT for OCD in situations where the formulation suggests key individuals also need to be involved in the treatment whether reducing their role in performing safety-seeking behaviours and/or by adding or increasing approach-supporting behaviours.

Key practice points

(1) It is essential to understand the language of the individual (and family members) and ensure that we adapt our explanations to match.
(2) Family members can have a range of reasons for the ways that they behave (which can become entangled within the OCD and help to maintain it) but in the majority of cases they are doing this because they care about the individual and want to relieve their distress.
(3) As therapists we are not immune from becoming entangled in safety-seeking behaviours (including reassurance) rather than approach-supporting behaviours and need to remain vigilant to that possibility.
(4) Our role is to help the person with OCD and those around them reduce their safety-seeking behaviours and reassurance seeking, working together to identify approach-supporting behaviours that family members can provide and be part of the overall strategy. Approach-supporting behaviours should feel acceptable to all and help the person at the centre to work towards reducing the impact of OCD on their life.

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