CBT for OCD and PTSD

Why a ritual makes an intrusive thought stronger, why trauma can feel like danger now, and how CBT works with both

DRAFT this text has not yet been approved by the author and may change.

19 chapters ~54 min read

How solid is each fact

Proven by research | Clinical consensus | In the author's own words | Interpretation / disputed | Documented fact | Not verified

In short

- **Almost everyone has intrusive thoughts.** In a study across 13 countries, 93.6% of students had at least one unwanted intrusive thought, image or urge in the previous three months. OCD is defined not by the thought itself but by what a person does with it.
- **A ritual is a painkiller that makes the pain worse.** Checking or washing eases anxiety for a few minutes, but it stops you from learning that nothing bad would have happened anyway. So the thought comes back more often.
- **The first treatment that worked for OCD was described in 1966.** Victor Meyer had two severely ill patients face what they feared while preventing their rituals. This grew into exposure and response prevention (ERP), today the core treatment for OCD.
- **In Salkovskis's cognitive model, the key is responsibility.** A thought becomes tormenting when a person reads it as a sign that "it's up to me whether something terrible happens".
- **CBT helps a lot with OCD, but the evidence is not flawless.** In a 2024 meta-analysis ERP had the largest effect of any psychological treatment, yet 87% of the trials were at high risk of bias.
- **Trauma is not the same as PTSD.** World Health Organization surveys suggest the disorder develops in about 5.6% of people who go through a traumatic event. A compulsory talk straight after the event (debriefing) did not prevent PTSD, and the UK's NICE guideline advises against it.
- **For PTSD the first-line treatments work with the trauma memory.** These are cognitive processing therapy (CPT), cognitive therapy for PTSD (CT-PTSD) and prolonged exposure (PE). EMDR is first-line for NICE and ISTSS; the American Psychological Association (APA) gives it a conditional recommendation.

- **Both disorders share one mechanism: avoidance.** People avoid "dangerous" inner content and so never get to learn that the danger is exaggerated or already in the past.

Timeline

How CBT treatment for OCD and PTSD took shape, from the first patients to today's guidelines. Details and sources are in the chapters below.

1966
Victor Meyer describes treating two patients with obsessional rituals: facing the fear without the ritual
BEHAVIOURAL LINE

1970s
Rachman, Hodgson and Marks in London test exposure and response prevention in controlled studies
BEHAVIOURAL LINE

1985
Paul Salkovskis proposes a cognitive model of OCD centred on responsibility for harm
COGNITIVE LINE

1986
Edna Foa and Michael Kozak: emotional processing theory of fear
BEHAVIOURAL LINE

2000
Anke Ehlers and David Clark: a cognitive model of persistent PTSD
COGNITIVE LINE

2002
Cochrane review: single-session debriefing does not prevent PTSD
EVIDENCE

2005
NICE guideline on OCD; Foa's trial of ERP versus clomipramine
EVIDENCE

2014 — Craske and colleagues: the inhibitory learning model; trial of intensive cognitive therapy for PTSD
EVIDENCE

2017 — APA guideline on treating PTSD in adults
EVIDENCE

2018 — NICE and ISTSS guidelines on PTSD
EVIDENCE

2024 — Meta-analysis of 48 trials of psychotherapy for OCD, with candid caveats about evidence quality
EVIDENCE

The lines are a way of telling the story: the behavioural line works with behaviour and facing fear, the cognitive line with how people make sense of events, and "Evidence" covers trials, meta-analyses and guidelines. Episode 1 explains the lines in more detail.

How to read these notes: evidence labels

Every claim carries a label in brackets that tells you how solid it is.

Proven by research means randomised trials (participants are split into groups by chance and the results compared) or meta-analyses (studies that pool many trials). **Clinical consensus** means clinical guidelines, such as the UK's NICE or the American APA. **The author's own account** is what a method's author or colleagues say. **Interpretation** is a reading of the facts that is still debated. **Documented fact** covers dates, publications and institutions. **Sources disagree** means we give both versions. **Not verified** means we could not open the primary source.

CBT is cognitive behavioural therapy. OCD is obsessive-compulsive disorder. PTSD is post-traumatic stress disorder.

Important This is education, not therapy or diagnosis. The methods below are described as they are used in therapy with a trained clinician; they are not self-help instructions. These notes discuss trauma (without describing events) and mention suicide risk. If you are struggling right now, see If you need help now at the end of the page.

What OCD is and what it isn't

The disorder starts not with a thought but with the conclusion a person draws from it.

A thought almost everyone has

You are standing on a platform and a picture flashes through your mind of stepping forward. Or you leave the house and think, "Did I turn the hob off?" Such thoughts are called **intrusive thoughts**, or intrusions: they arrive uninvited and feel alien.

In 2014 Canadian psychologist Adam Radomsky and colleagues surveyed 777 students in 13 countries on six continents. 93.6% had experienced at least one unwanted intrusive thought, image or urge in the previous three months; doubts were the most common kind **proven by research; Radomsky et al., 2014**. Paul Salkovskis, who developed the cognitive model of OCD, writes that such thoughts occur in at least 90% of people, and that their content is largely the same in people with and without OCD **the author's own account; Salkovskis, 1999**.

So what makes the difference? Radomsky's short answer: "it's what you make of those thoughts" **the author's own account; Concordia University, 2014**. Most people shrug it off as a weird thought. A person with OCD concludes: "If I thought it, it must mean something. It could happen. And if it does, it will be my fault."

How the diagnostic manuals describe OCD

Under the American DSM-5, OCD means obsessions, compulsions or both **documented fact; DSM-5 as set out by Beyond OCD**:

- **Obsessions** are recurrent thoughts, urges or images that feel intrusive and unwanted and cause marked anxiety or distress. The person tries to ignore, suppress or "neutralise" them.
- **Compulsions**, or rituals, are repetitive behaviours (washing, checking, ordering) or mental acts (praying, counting, repeating words) that the person feels driven to perform to prevent anxiety or a dreaded event, even though they are not realistically connected to it or are clearly excessive.
- All this **takes time** (for example, more than an hour a day) or causes significant distress and gets in the way of life.

Clinicians also note the level of **insight**, meaning how far the person recognises that their fears are probably exaggerated, from good to absent **documented fact; Beyond OCD**. The international ICD-11 classification has a similar description and groups OCD with body dysmorphic disorder, hypochondriasis and hoarding **not verified against the WHO website**.

OCD, perfectionism and "I'm so OCD"

On social media "OCD" has become a word for being tidy. But the key difference is how a person experiences their thoughts and actions. The table is a summary drawn from clinical

descriptions (interpretation; based on Radomsky et al., 2014; DSM-5).

	OCD	Perfectionism, love of order	Obsessive-compulsive personali
How it feels	Alien and unwanted	One's own: "I like things neat"	One's own; character traits
What for	To prevent disaster or relieve an unbearable "not right" feeling	For quality and the pleasure of the result	For control and rules
Cost	Hours a day, suffering, damage to life	Doesn't interfere, or only a little	Rigidity at work and in relationsh
Themes	Contamination, harm, doubt, symmetry, sexual or religious thoughts	Neatness, standards	Order, morality, thrift

People with OCD are often afraid of exactly what most contradicts their values. That is why many stay silent for years: they are ashamed and afraid of being seen as dangerous.

Myth vs fact **Myth:** OCD is a love of order. **Fact:** order and symmetry are only one theme. What defines OCD is unwanted thoughts and rituals that take hours and get in the way of life **documented fact; DSM-5 as set out by Beyond OCD**.

How common it is

In the US National Comorbidity Survey Replication, 2.3% of adults had OCD at some point in their life and 1.2% in the past year, while over a quarter had experienced individual obsessions or compulsions at some point **proven by research; Ruscio et al., 2010**. In WHO surveys across 10 countries (26,136 people, 2025) the figures were 4.1% lifetime and 3.0% in the past year **proven by research; Stein et al., 2025**. These are different studies with different countries and methods, so the numbers should not be read as "OCD is rising".

The more important figure: in those WHO surveys only 19.8% of people with OCD had received any treatment in the past year, 40.5% in high-income countries and 7.0% in low- and middle-income ones **proven by research; Stein et al., 2025**.

Chapter sources: Radomsky et al., 2014 · Concordia University, 2014 · Salkovskis, 1999 · Beyond OCD: DSM-5 criteria · Ruscio et al., 2010 · Stein et al., 2025

1966: two patients and a tap turned off

Where the treatment at the heart of every OCD guideline began.

Until the mid-1960s OCD was seen as one of the hardest conditions to treat (interpretation; Salkovskis & Wahl). A benchmark from that era: the Norwegian psychiatrist Kringlen followed 82 patients with obsessional problems for 13 to 20 years, and only 21 improved significantly **documented fact, as retold; Lipsedge, 1979**.

In 1966 the British psychologist Victor Meyer, who worked at the Middlesex Hospital Medical School in London, published "Modification of expectations in cases with obsessional rituals" in *Behaviour Research and Therapy* **documented fact; Meyer, 1966**.

What he did is known mainly from the account of psychologist Stanley Rachman, one of the leading OCD researchers **the author's own account; Rachman, 2005, via OCD History**. There were two hospitalised patients, neither helped by earlier treatments. One was so afraid of dirt and disease that she spent most of the day cleaning. Meyer, and later a nurse, exposed her to objects that triggered her anxiety and stopped her carrying out her cleaning rituals; the water in her room was turned off and her access to cleaning products severely limited. After eight weeks her compulsive cleaning had dropped to tolerable levels. For the second patient it took nine weeks.

> "Neither was cured; but both regained normal lives." Rachman, 2005, via OCD History.

Rachman called the consequences of this success "spectacular": Meyer, he said, "had broken the ice" **the author's own account; Rachman, 2005, via OCD History**. In a 2009 article Rachman is more measured, calling the result "partially successful" **the author's own account; Rachman, 2009, via OCD History**.

Accounts of the second case differ: Rachman describes intrusive thoughts and hours spent getting dressed, while Lipsedge's 1979 review describes two patients with hand-washing rituals **sources disagree; OCD History; Lipsedge, 1979**. We could not open the full text of Meyer's paper.

Why "expectations" is in the title

Meyer assumed the patient expected a catastrophe: if I don't wash or check, something terrible will happen. The rituals would stop if that expectation changed **documented fact; Lipsedge, 1979**. If the ritual is not performed and no catastrophe follows, the expectation is disproved. This is, in effect, a cognitive idea inside a behavioural method (interpretation; Salkovskis & Wahl).

Meyer's work grew into **exposure and response prevention** (ERP). **Exposure** means deliberately facing what you fear. **Response prevention** means giving up the ritual that would normally relieve the anxiety. In the 1970s Rachman, Hodgson and Marks at London's Maudsley Hospital tested the approach in controlled studies **documented fact; Salkovskis & Wahl**. Today ERP is far gentler than in 1966: nobody turns off the water, and the person chooses with the therapist where to start and decides when to go further.

Chapter sources: OCD History: Behavior therapy for OCD · Meyer, 1966 · Lipsedge, 1979 · Salkovskis & Wahl

How an ordinary thought turns into OCD

The five-step cycle and Salkovskis's cognitive model: what keeps the disorder going.

The OCD cycle, step by step

Take the most common and safest example: checking.

1. **Intrusion.** "What if the hob is still on?" The thought on its own is not a disorder.
2. **Anxiety, via appraisal.** What causes the anxiety is not the thought but the conclusion: "If I don't check and there's a fire, it'll be my fault."
3. **Ritual.** Go back and check. Touch the knobs. Take a photo of the hob. Ask a partner: "Are you sure you saw it was off?" Some rituals are invisible: silently repeating "I remember the click", or cancelling a bad thought with a good one.
4. **Short-lived relief.** Anxiety drops, quickly and briefly. That relief is exactly what reinforces the ritual.
5. **Strengthening.** The brain concludes: "The danger was real, and checking saved me." There is no way to find out what would have happened without checking. The thought seems more important, it gets monitored and suppressed, and it comes back more often. Next time one check is not enough.

Behavioural accounts call this negative reinforcement: a behaviour is strengthened because it removes an unpleasant feeling (interpretation; the two-factor model as described by Salkovskis & Wahl). In Rachman and colleagues' 1976 experiments, a ritual reduced discomfort immediately, but without the ritual the discomfort and the urge also faded on their own, just

more slowly proven by research, one study as retold; Salkovskis & Wahl. People with OCD usually don't know this, because they never wait long enough.

Salkovskis's model: inflated responsibility

In 1985 British psychologist Paul Salkovskis published a cognitive-behavioural analysis of OCD. His question: if almost everyone has intrusive thoughts, what makes them torment some people? His answer: the intrusive thought is a stimulus, not a symptom; the distress begins with the reaction to it, and that reaction is linked to beliefs about responsibility or blame for harm to oneself or others documented fact; Salkovskis, 1985.

Salkovskis later gave responsibility a precise definition the author's own account; Salkovskis, 1999:

> "The belief that one has power which is pivotal to bring about or prevent subjectively crucial negative outcomes." Salkovskis, 1999.

An everyday example. Someone sees a nail on the road and thinks: "If I don't move it, someone will get a puncture, crash, and it'll be on me." For most people the thought passes. For someone with inflated responsibility it becomes an order: move the nail, then go back to check it's gone.

In the model, the appraisal "it's my responsibility" triggers anxiety and an urge to **neutralise** the thought, that is, to cancel it out in any way possible. Neutralising in turn makes the intrusions more frequent and the threat and responsibility seem weightier. The circle closes the author's own account; Salkovskis, 1999.

Theory A and Theory B

In therapy Salkovskis invites the person to compare two explanations the author's own account; Salkovskis, 1999:

- **Theory A:** "I am contaminated (or dangerous), and I have to wash and control everything to protect the people I love."
- **Theory B:** "I am someone who, for understandable reasons, is very sensitive to worries about contamination (or harm), and the way I react to that worry makes it worse."

In his own words: "Maybe you are not dangerous, but are very worried about being dangerous" the author's own account; Salkovskis, 1999. The person and therapist then use behavioural experiments to test which theory fits the facts better.

Six kinds of belief

Later, an international group of researchers, the Obsessive Compulsive Cognitions Working Group (OCCWG), described six kinds of belief that sustain the disorder and built questionnaires to measure them documented fact; OCCWG / Steketee et al., 2005:

1. **Inflated responsibility:** "it's up to me whether something terrible happens".
2. **Overimportance of thoughts**, including **thought-action fusion**: "thinking something bad is almost as bad as doing it", "if I think it, it will happen".
3. **Importance of controlling thoughts:** "I must not think this".
4. **Overestimation of threat:** "bad things are likely and will be awful".
5. **Intolerance of uncertainty:** being unable to bear "maybe".
6. **Perfectionism:** "it has to be perfect or it's a failure".

In a validation with 893 participants, the six groups boiled down to three factors: responsibility and threat; perfectionism and uncertainty; importance and control of thoughts **proven by research; OCCWG / Steketee et al., 2005**. How specific these beliefs are to OCD rather than to anxiety in general is not fully settled (interpretation; OCCWG / Steketee et al., 2005).

Important **Why looking for a "hidden wish" in an intrusive thought backfires.** When someone comes in with a thought that frightens them, interpreting it as a secret desire only confirms, according to the cognitive model, that the thought matters, and the cycle spins faster (interpretation; based on Salkovskis, 1985, 1999). CBT works not with the content of the thought ("what it says about you") but with the response to it ("what you do with it"). Repeated questions like "am I sure I'm not like that?" are also a form of reassurance seeking, and answering them on their own terms works like a ritual.

Chapter sources: Salkovskis, 1985 · Salkovskis, 1999 · OCCWG / Steketee et al., 2005 · Salkovskis & Wahl

How ERP breaks the cycle

A composite example: what exposure and response prevention looks like in therapy, and why it works.

Example **Anna** (a composite, not a real client), 34. Before leaving home she checks the hob, the iron and the lock. At first once each; a year later five times; now leaving takes 40 minutes and she often turns back halfway. Several times a day she calls her husband: "Are you sure the hob was off?" He says yes. The thought behind it all: "If there's a fire, it'll be my fault." Her anxiety is 80 out of 100 before checking and 30 after, but only for 10 to 15 minutes.

This is how ERP is typically structured in therapy (clinical consensus; the general structure of Foa and colleagues' protocols; the protocol manual itself was not consulted):

1. **Assessment.** A clinical interview, severity scales, and screening for other conditions: depression, tics, suicide risk.
2. **Psychoeducation.** Anna and the therapist draw her cycle together. Anna learns that almost everyone has such thoughts, and that the ritual protects not her home from fire but her anxiety from a reality check. The therapist offers Salkovskis's two versions: "I'm a person who could cause a fire" and "I'm a person who is terrified of being to blame". ERP does not begin without the person's understanding and consent.
3. **A list of rituals, including invisible ones.** Checking, photos, calls to her husband, the silent "I remember the click", avoiding cooking before going out.
4. **A hierarchy.** Situations are rated on a 0–100 scale of subjective distress (known as SUDS). People usually start in the middle, with what they feel ready to try.
5. **Exposure with response prevention.** Anna turns off the hob once, in an ordinary way, and leaves. Beforehand she writes down what she expects; afterwards, what actually happened.
6. **No neutralising in her head.** If she hears "I definitely remember the click", that is a ritual too. The therapist teaches her to answer the thought differently: "Maybe the hob is on. I'm leaving that uncertainty as it is." The goal is not to convince herself that everything is safe, but to stop demanding 100% certainty.
7. **Family.** Her husband agrees with the therapist on a supportive phrase to use instead of "yes" (more in the chapter on family).
8. **Homework and relapse prevention.** Daily practice with a diary, and a plan for when rituals creep back in stressful times: a lapse is not a relapse.

Anna's hierarchy might look like this (our example, for illustration):

Situation	Distress, 0–100
Check the hob once instead of five times	40
Leave without photographing the hob	50
Go a whole day without calling her husband to ask	60
Leave without checking the hob at all	75
Cook and then leave straight away without checking	85
Go away for the weekend after one quick check	90

For obsessions that cannot be recreated in real life (for example, fear of causing harm), therapists use **imaginal exposure**: the person reads or listens to a script of the feared

outcome, written together with the therapist, without neutralising it clinical consensus; the standard structure of protocols.

Why it works: two explanations

Emotional processing (Foa and Kozak, 1986). Fear is stored in memory as a structure: a representation of the feared stimulus, the person's responses and what it all means to them. For fear to change, the structure has to be activated and information that is incompatible with it has to be added. The authors saw arousal during exposure and **habituation**, the gradual drop in anxiety within and between sessions, as signs of processing documented fact; Foa & Kozak, 1986.

Inhibitory learning (Craske and colleagues, 2014). Exposure does not erase the old link "thought = danger"; it builds a new, competing one on top of it: "thought without ritual = bearable and safe". On this view, what matters is not how far anxiety fell during an exercise but the fact that an expectation was not met (for example, "I won't last ten minutes"). The authors propose eight strategies, including **expectancy violation**, varying contexts, variability and dropping "safety signals" documented fact; Craske et al., 2014. This is a model, not a fully proven mechanism (interpretation). Episode 8 covers how exposure works in other anxiety disorders.

Common pitfalls in ERP

Clinicians point to traps that stop exposure working clinical consensus; based on the training literature, no single source checked:

- the therapist reassures: "No, you're definitely not dangerous", which is the same ritual, just in the consulting room;
- mental rituals go unnoticed: counting, praying, a "good" thought to replace a "bad" one, endless analysis of "why did I think that";
- small safety behaviours during exposure go unnoticed: wiping hands on trousers, distraction, telling yourself "this one doesn't count";
- relaxation is used to "get through" the exercise and becomes a safety behaviour in its own right.

Important This shows the logic of the method; it is not a self-treatment guide. ERP is done with a trained clinician. If rituals take more than an hour a day or get in the way of life, see a psychotherapist who works with OCD, or a psychiatrist.

Chapter sources: Foa & Kozak, 1986 · Craske et al., 2014 · Salkovskis, 1999

Does it work, and are pills needed?

What meta-analyses and guidelines say about CBT and medication for OCD.

The numbers

One term first. An **effect size** (written g or d) shows how much one group differs from another: around 0.2 is a small difference, around 0.5 medium, 0.8 or more large.

- **Öst and colleagues, 2015**: 37 randomised trials of CBT for OCD published 1993–2014. CBT versus waiting list: g = 1.31; versus placebo: g = 1.33, both very large. ERP and cognitive therapy did not differ significantly (0.07), nor did group and individual formats (0.17). CBT was significantly more effective than antidepressants (g = 0.55), and adding medication to CBT gave no significant gain over CBT plus placebo (0.25) **proven by research; Öst et al., 2015**.
- **Wang and colleagues, 2024**: 48 trials, 2,731 patients. Psychotherapy versus control: g = 1.14 (reported with a minus sign in the paper, meaning fewer symptoms). The largest effect was for ERP (1.25), with CBT at 1.13. Cognitive therapy on its own and third-wave approaches did not show a significant effect versus control **proven by research; Wang et al., 2024**.

Fact **The caveats that rarely make headlines.** In the same 2024 meta-analysis, 87% of trials were at high risk of bias. After adjusting for unpublished studies the effect fell to 0.88 or 0.59, depending on the method, but stayed significant. In the three trials at low risk of bias the effect (0.87) was no longer statistically significant. There are few results at 3–12 months and they are not significant **proven by research; Wang et al., 2024**. This does not mean CBT "doesn't work". It means there is less high-quality evidence than one big number suggests (interpretation). Episode 14 looks at how to read caveats like these.

An open puzzle: cognitive therapy without exposure

In 2015 cognitive therapy was as good as ERP; in a 2016 network meta-analysis it showed a strong effect versus placebo (−13.36 points on the Y-BOCS scale); yet in 2024, on its own against control, it showed no significant effect **sources disagree; Öst et al., 2015; Skapinakis et al., 2016; Wang et al., 2024**. A likely explanation is that good cognitive therapy for OCD contains so many behavioural experiments that the line between it and exposure is blurred (interpretation). The question is open.

Pills

In a 2005 trial by Edna Foa and colleagues, 122 adults with OCD were divided into four groups. The share who responded to treatment, among everyone who started and among those who completed **proven by research; Foa et al., 2005**:

Group	All who started	Completers
Exposure and ritual prevention	62%	86%
Clomipramine (an antidepressant)	42%	48%
Exposure + clomipramine	70%	79%
Placebo	8%	10%

All three active treatments beat placebo; adding clomipramine to exposure did not significantly improve the result; exposure and the combination both beat medication alone **proven by research; Foa et al., 2005**.

In Skapinakis and colleagues' 2016 network meta-analysis (54 trials, 6,652 participants), behaviour therapy reduced Y-BOCS scores versus placebo by 14.48 points and SSRI antidepressants by 3.49 **proven by research; Skapinakis et al., 2016**. But the authors themselves warn that in 12 of the 15 psychotherapy trials participants could be taking antidepressants at a stable dose, and the data on combinations are very small. So this cannot be presented as "therapy is four times better than pills". The authors think the combination is probably better than psychotherapy alone, at least for severe OCD (interpretation by the authors; Skapinakis et al., 2016).

NICE's stepped care

The UK's NICE guideline arranges care in steps **clinical consensus; NICE CG31, 2005**:

Severity	What is offered
Mild functional impairment	Low-intensity CBT including ERP, up to 10 therapist hours, including group or guided self-help formats
Moderate	A choice of an SSRI antidepressant or more intensive CBT including ERP (more than 10 hours)
Severe	An SSRI combined with CBT including ERP

If medication helps, NICE advises continuing it for at least 12 months **clinical consensus; NICE CG31**. In 2019 NICE decided to update the guideline **documented fact; NICE, 2019**; as of November 2026 we found no updated version in open sources. Only a doctor can start or stop medication.

Chapter sources: Öst et al., 2015 · Wang et al., 2024 · Foa et al., 2005 · Skapinakis et al., 2016 · NICE CG31 · NICE, 2019

Family: when love feeds OCD

Why a tenth "yes, it's off" works as one more ritual.

Anna's husband says "yes" for the tenth time. A mother waits twenty minutes for her child to finish washing before starting dinner. A partner washes their hands before a hug. This is called **family accommodation**: relatives taking part in rituals and avoidance in ways that ease the person's distress in the moment **documented fact; Sperling et al., 2025**.

- In a meta-analysis of 39 studies, accommodation happened at least monthly in 95.3% of families, at least weekly in 93.2% and daily in 47.6%. The most common forms were reassurance and waiting for a ritual to finish **proven by research; Pellegrini et al., 2025**. The studies vary a lot, so treat this as a guide rather than a precise figure.
- More accommodation goes with more severe OCD on average: r = 0.35 across 14 studies and r = 0.42 across 41 **proven by research; Strauss et al., 2015; Wu et al., 2016**. This is an association, not proof that accommodation causes severity; it may also work the other way round.
- Whether accommodation gets in the way of treatment is unclear: in a 2024 meta-analysis, baseline accommodation did not predict outcome, and treatment reduced it even without dedicated family modules (sources disagree; Hermida-Barros et al., 2024, as reported in Pellegrini et al., 2025; Sperling et al., 2025).

Relatives do this out of love, and there is nothing to blame them for. But every "yes, everything's fine" relieves anxiety for a minute and keeps the cycle going. That is why NICE says plainly that if family members are involved in compulsions, avoidance or reassurance, the treatment plan should help them reduce that involvement sensitively and supportively, and that children and young people should be treated with the family actively involved **clinical consensus; NICE CG31, quick reference guide, 2005**.

Example **What to say instead of "yes".** As agreed in advance with the therapist: "I can see you're anxious. We agreed I won't answer that question. I believe you can handle this." Not abruptly and not as a punishment, but according to the plan.

A parent programme called SPACE (Supportive Parenting for Anxious Childhood Emotions, developed by Eli Lebowitz) uses similar logic: parents learn to reduce accommodation and express support. In a 2020 trial with 124 children aged 7–14 with anxiety disorders, the parent-only programme was not inferior to CBT delivered to the child **proven by research; Lebowitz et al., 2020**. Note that this trial was about anxiety disorders, not OCD.

Chapter sources: Pellegrini et al., 2025 · Strauss et al., 2015 · Wu et al., 2016 · Sperling et al., 2025 · NICE CG31 · NICE CG31, quick reference guide · Lebowitz et al., 2020

OCD's relatives: body dysmorphic disorder and hoarding

Two disorders from the same "family" as OCD, and what CBT knows about them.

DSM-5 (2013) introduced a separate chapter, "Obsessive-Compulsive and Related Disorders". Alongside OCD it includes body dysmorphic disorder, trichotillomania (hair pulling), excoriation (skin picking) and hoarding disorder; hoarding became a diagnosis in its own right for the first time rather than a symptom of OCD. What these disorders share is obsessive preoccupation and repetitive behaviour **documented fact; DSM-5, via The Carlat Report**.

Body dysmorphic disorder

Body dysmorphic disorder (BDD) is a distressing preoccupation with a flaw in one's appearance that others can't see or consider minor: skin, nose, hair, body shape. The person spends hours checking mirrors or avoids them altogether, compares themselves with others, camouflages the "defect" and asks family whether they look all right (interpretation; general description). It isn't vanity: the preoccupation is experienced as shame and fear.

The CBT logic is the same as in OCD: checking, camouflage and avoidance relieve anxiety briefly and keep the belief "something is wrong with me" alive. So the core of treatment is CBT with exposure and response prevention (ERP) — for example, going out without camouflage and not checking one's reflection. For moderate impairment, NICE offers a choice between an SSRI antidepressant and more intensive individual CBT with ERP that addresses the key features of BDD; for severe or long-standing problems, the two combined and specialist care **clinical consensus; NICE CG31, quick reference guide, 2005**.

In a 2016 meta-analysis (7 randomised trials, 299 participants), CBT clearly outperformed a waitlist or a credible psychological placebo: $\Delta = -1.22$, a large effect; the improvement held at 2–4 months **proven by research; Harrison et al., 2016**. There are few trials and follow-up is short, and the authors themselves call for testing long-term effects against active controls.

> Important NICE advises clinicians to keep BDD in mind when someone with a minor blemish asks for cosmetic surgery or attends a dermatology clinic, and, if BDD is suspected, to refer them for assessment by a mental health professional with expertise in the disorder **clinical consensus; NICE CG31, quick reference guide, 2005**.

Hoarding disorder

Hoarding disorder is a persistent difficulty parting with possessions regardless of their value: throwing things away is distressing, and possessions gradually take over living space so that it becomes hard to use as intended (interpretation; general description). A meta-analysis of 11 studies (53,378 people) puts its prevalence at about 2.5% **proven by research; Postlethwaite et al., 2019**.

CBT for hoarding usually works on motivation, sorting and decision-making skills, beliefs about possessions and gradual exposure to letting things go, rather than a forced "big clear-out"; the best-known programme is by Gail Steketee and Randy Frost (interpretation; general description, the authors' manual was not opened — not verified).

The evidence here is more modest than for OCD. In a 2015 meta-analysis (10 studies, 232 people), symptoms fell significantly after CBT, most of all difficulty discarding **proven by research; Tolin et al., 2015, via NEJM Journal Watch**. The overall effect was large (g = 0.82), but for most participants — 57–76% — the change fell short of clinically significant **proven by research; Tolin et al., 2015, as reported by Twigger et al., 2024**. An honest benchmark: CBT for hoarding helps, but it more often reduces the problem than resolves it (interpretation).

Neither BDD nor hoarding is about character, vanity or laziness. Both are disorders with understandable maintaining cycles, and they are treated with the same care and planning as OCD (interpretation).

Chapter sources: The Carlat Report: DSM-5 · NICE CG31, quick reference guide · Harrison et al., 2016 · Postlethwaite et al., 2019 · Tolin et al., 2015 · Twigger et al., 2024

Trauma and PTSD: why past danger feels present

Does every trauma become a disorder, what helps in the first weeks, and why it doesn't pass for some people.

> **Important** This chapter is about trauma. No events are described, only general definitions. If reading brings up strong feelings, you can skip it or come back later. If you have thoughts that you don't want to live, please don't stay alone with them: see If you need help now.

What counts as trauma, and what counts as PTSD

Under DSM-5, a **traumatic event** means exposure to actual or threatened death, serious injury or sexual violence: directly, as a witness, by learning that it happened to someone close, or through repeated exposure to details at work, as with emergency workers **not verified: standard wording, the full DSM-5-TR text was not consulted**.

PTSD consists of four groups of symptoms that last more than a month and get in the way of life documented fact; the structure of the PCL-5, Center for Deployment Psychology:

Group	In plain words
Intrusions	Unwanted memories, nightmares, feeling it is happening again; strong reactions to reminders
Avoidance	Steering clear of thoughts, feelings, places and people linked to the event
Changes in thinking and mood	"I'm broken", "no one can be trusted", guilt, shame, loss of interest
Arousal and reactivity	Hypervigilance, being easily startled, irritability, poor sleep and concentration

ICD-11 also includes **complex PTSD**: all the features of PTSD plus lasting difficulties regulating emotions, a negative self-image with shame or guilt, and difficulties in relationships documented fact; Brewin, 2020; NICE NG116.

Does every trauma become PTSD?

No. In 26 WHO surveys (71,083 adults), lifetime PTSD was found in 3.9% of all respondents and in 5.6% of those who had experienced a traumatic event. About half of people with PTSD had persistent symptoms. Help was sought by 53.5% in high-income countries and 22.8–28.7% in lower-income ones proven by research; Koenen et al., 2017.

Most people sleep badly, keep remembering and startle easily for a while after a terrible event, and then gradually recover. NICE describes early reactions that don't seriously disrupt daily life as a normal reaction to an abnormal event clinical consensus; Megnin-Viggars, 2019, a summary of NICE NG116. If yours hasn't passed, that is not weakness: this is exactly what treatment is for.

Myth vs fact **Myth:** you should talk it all through straight after the event, while it's fresh. **Fact:** a Cochrane review of 15 trials found that a single session talking through the event soon afterwards (psychological debriefing) did not prevent PTSD or reduce distress; in one trial PTSD was more common a year later among those who had been debriefed (odds ratio 2.51) proven by research; Rose et al., 2002. NICE: "Do not offer psychologically-focused debriefing for the prevention or treatment of PTSD" clinical consensus; NICE NG116, 1.6.5.

What to do instead. For people with symptoms below the diagnostic threshold within a month of the event, NICE suggests considering **active monitoring**, with a follow-up contact within a month (**clinical consensus; NICE NG116, 1.6.4**). Jonathan Bisson, one of the authors of the international guidelines, describes the first step as practical, compassionate support, which family and friends can give; if symptoms persist or worsen after about a month, trauma-focused therapy follows (**the author's own account; Bisson, via MDedge, 2019**).

Why it doesn't pass for some: the Ehlers and Clark model

In 2000 British psychologists Anke Ehlers and David Clark proposed a cognitive model of persistent PTSD. Its central idea: PTSD persists when people process the trauma in a way that leads to a sense of serious, current threat, even though the event is in the past (**documented fact; Ehlers & Clark, 2000**). Two processes create this sense:

1. **Negative appraisals** of the trauma and its aftermath: "nowhere is safe", "I'm broken for good", "it was my fault", "these symptoms mean I'm going mad".
2. **The nature of the trauma memory.** The memory is poorly integrated into the person's life story and not "tagged" as past, yet it is strongly linked to individual sensations. So a similar smell or sound can trigger an intrusion without the person knowing why it suddenly hit them (**documented fact; Ehlers & Clark, 2000**).

The third element is **strategies that block recovery**: trying not to think about it, going over things again and again, hypervigilance, avoidance and small "just in case" behaviours (interpretation; the standard account of the model; the abstract refers to "problematic behavioural and cognitive strategies").

An everyday example (composite). After a car accident someone spends months only travelling as a passenger, gripping the door handle and constantly watching the mirror. Every uneventful trip feels like "lucky I was on guard" rather than "the danger has passed". In this way safety behaviour stops the appraisal "I'm in danger" from changing.

Chapter sources: Koenen et al., 2017 · Center for Deployment Psychology: PCL · Brewin, 2020 · Rose et al., 2002 · NICE NG116 · Megnin-Viggars, 2019 · MDedge, 2019 · Ehlers & Clark, 2000

Three CBT protocols for PTSD

Prolonged exposure, cognitive processing therapy and cognitive therapy for PTSD: how each puts the memory back in the past.

All first-line treatments for PTSD are **trauma-focused**: they work with the trauma memory, but in a structured, gradual way, after preparation, with a trained clinician. For adults NICE names four forms of trauma-focused CBT: cognitive processing therapy (CPT), cognitive therapy for

PTSD (CT-PTSD), narrative exposure therapy (NET) and prolonged exposure (PE), typically over 8 to 12 sessions, more if clinically indicated clinical consensus; NICE NG116, 1.6.16–1.6.17.

Prolonged exposure (PE), Edna Foa

The logic is the same as ERP for OCD. People avoid memories and safe situations that are reminders of the event, so the brain never gets the information that the danger is over. The method rests on emotional processing theory (see the chapter on ERP).

According to the APA, PE usually takes 8 to 15 weekly sessions of 60 to 120 minutes, over about three months. It includes psychoeducation about trauma, a breathing technique, **imaginal exposure** (with the therapist's help the person recounts the memory several times in the present tense and then discusses what has changed in how they understand it), **in vivo exposure** (gradually returning to avoided safe situations according to an agreed plan) and listening to a recording of the session at home clinical consensus; APA, PE.

In a 2010 meta-analysis (13 trials, 675 participants), PE had a large effect versus control after treatment, g = 1.08; the average person after PE did better than 86% of people in control groups. There was no significant difference from other active treatments (CPT, EMDR, cognitive therapy) proven by research; Powers et al., 2010. Foa herself is among the authors.

Cognitive processing therapy (CPT), Patricia Resick

Here the focus is not the memory itself but the conclusions a person has drawn from it. Resick and colleagues developed the method in the early 1990s for survivors of sexual assault; in the first study, in 1992, 19 women attended 12 weekly group sessions and their PTSD and depression symptoms fell, while a waiting-list group did not change documented fact; Resick & Schnicke, 1992, from the abstract.

- **12 core sessions** documented fact; Center for Deployment Psychology.
- **An Impact Statement**: in the first session the person writes what the trauma means to them and why they think it happened; towards the end they rewrite it and see what has changed.
- **"Stuck points"**: beliefs that block recovery, such as "I should have prevented it" or "no one can be trusted". They are identified and gently examined with questions and worksheets.
- **Five themes** that trauma typically affects: safety, trust, power and control, esteem, intimacy documented fact; Center for Deployment Psychology.

Resick describes two thinking traps. **Assimilation**: the person changes their understanding of the event to keep their old picture of the world, as in "if this happened to me, I must have deserved it". **Over-accommodation**: the picture of the world changes too much, as in "nowhere is safe" (interpretation; based on descriptions of the CPT protocol).

In a meta-analysis of 11 trials (1,130 participants), CPT versus inactive control had g = 1.24 after treatment and 0.90 at follow-up; against other active treatments CPT did better right after treatment but not later (proven by research; Asmundson et al., 2019).

Cognitive therapy for PTSD (CT-PTSD), Anke Ehlers and David Clark

This method follows directly from the 2000 model and targets its three parts (documented fact; Ehlers et al., 2014; Ehlers & Clark, 2000):

- **Updating "hotspots".** The moments in the memory with the most pain and meaning are identified and updated with what was not known at the time: "I survived", "it wasn't my fault", "it can't hurt me any more".
- **Telling "then" from "now".** The person learns to notice how today's sound or smell differs from the one back then.
- **Reclaiming your life.** Gradually returning to activities and relationships given up after the trauma, and dropping unnecessary safety behaviours.

In a 2014 trial, 121 people with chronic PTSD were divided into four groups. The share who no longer met criteria for PTSD (proven by research; Ehlers et al., 2014):

Group	No longer had PTSD after treatment
Intensive cognitive therapy over 7 days	73%
Standard weekly cognitive therapy over 3 months	77%
Emotion-focused supportive therapy	43%
Waiting list	7%

The authors conclude that therapy delivered over little more than a week worked as well as therapy over three months. Around 3% dropped out of the cognitive therapy groups and 10% out of supportive therapy (proven by research; Ehlers et al., 2014). Caveat: the sample was small and the trial was run by the method's developers.

For children: TF-CBT

Trauma-focused CBT for children and adolescents (TF-CBT) was developed by Judith Cohen, Anthony Mannarino and Esther Deblinger. It is designed for ages 3 to 18, usually 12 to 16 weekly sessions, up to 25 for complex trauma. Non-offending parents or caregivers always take part: part of every session is with them alone, and there are joint sessions too (documented fact; Child Welfare Information Gateway, 2018). For ages 7 to 17, NICE recommends individual TF-CBT, usually 6 to 12 sessions, and advises against drug treatment to prevent or treat PTSD in under-18s (clinical consensus; NICE NG116, 1.6.11, 1.6.12, 1.6.14).

The three protocols side by side

	PE	CPT	CT-PTSD
Developer	Edna Foa	Patricia Resick	Anke Ehlers, David Clark
Main target	Avoidance of the memory and of situations	Conclusions drawn from the trauma, "stuck points"	Appraisals and memory features that create a sense of threat "now"
Main tool	Repeatedly recounting the memory and gradually returning to situations	Written assignments and examining beliefs	Updating hotspots, telling "then" from "now", reclaiming life
Length	8–15 sessions	12 sessions	About three months weekly, or intensive over 7 days

Myth vs fact **Myth:** you shouldn't talk about trauma, it retraumatises. **Fact:** first-line treatments work with the memory, but in a structured way and with preparation **clinical consensus; NICE NG116; Lewis et al., 2020**. To be honest about the cost: symptoms can get temporarily worse, and NICE advises warning people about this in advance **clinical consensus; Infocop, 2019, a summary of NICE NG116**; and people drop out of these treatments more often than out of other psychological therapies **proven by research; Bisson & Olff, 2021**.

Important Exposing yourself to trauma memories on your own, without a clinician, is not recommended. Before any trauma work a clinician assesses safety: suicide risk, ongoing abuse, severe dissociation, substance use.

Chapter sources: NICE NG116 · APA: Prolonged Exposure · Powers et al., 2010 · Center for Deployment Psychology: CPT · Asmundson et al., 2019 · Ehlers et al., 2014 · Child Welfare Information Gateway, 2018 · Infocop, 2019 · Bisson & Olff, 2021

EMDR compared, and what the guidelines say

Where CBT and EMDR agree, where experts disagree, and where medication fits.

What EMDR is

EMDR (eye movement desensitisation and reprocessing) was developed by American psychologist Francine Shapiro; the first study appeared in 1989: 22 people, with no control group **documented fact; Shapiro, 1989, from the abstract**. The method has eight phases. The person holds in mind a distressing memory, a related negative belief about themselves and a body sensation, while following the therapist's hand movements with their eyes or receiving another form of bilateral stimulation (interpretation; the standard description of the method).

Does it work?

According to the evidence, yes. In a network meta-analysis of 90 trials (6,560 participants) that underpins the NICE guideline, EMDR showed the largest reduction in symptoms versus waiting list (standardised mean difference −2.07), with trauma-focused CBT at −1.46; both effects held at 1–4 months; evidence quality was moderate to low **proven by research; Mavranezouli et al., 2020**.

What is disputed is what makes it work. A 2001 meta-analysis of 34 studies found no difference between EMDR and other exposure techniques, and the version without eye movements worked just as well. The authors concluded that "the eye movements integral to the treatment, and to its name, are unnecessary" **proven by research; Davidson & Parker, 2001**. The data are old; whether later studies reached a different conclusion was not checked for these notes **not verified**. Critics argue that the active ingredient is shared with CBT: returning to the memory and seeing it in a new light; EMDR proponents disagree (interpretation).

Three sets of guidelines

	NICE (UK, 2018)	APA (US, 2017)	ISTSS (international, 2018–2019)
CPT, CT-PTSD, PE	Offer as forms of trauma-focused CBT (1.6.16)	Strong recommendation	Strong recommendation
EMDR	Consider at 1–3 months, offer after 3 months, for non-combat trauma (1.6.18–1.6.19)	Conditional recommendation	Strong recommendation
NET	A form of trauma-focused CBT (1.6.16)	Conditional recommendation	—
Medication for adults	Consider venlafaxine or an SSRI such as sertraline if the person prefers medication (1.6.25)	Conditional: fluoxetine, paroxetine, sertraline, venlafaxine	—
Debriefing	Do not offer (1.6.5)	—	—

Labels: **clinical consensus; NICE NG116; APA, 2017, condensed version; Bisson & Olff, 2021**. Cells with a dash were not checked for these notes. In its official 2019 summary, the APA itself notes that future reviews could raise EMDR and NET to a strong recommendation **documented fact; APA, 2019**. The disagreement between the APA and NICE/ISTSS on EMDR is a genuine expert debate (interpretation).

One detail for accuracy. On the APA's treatments web page, cognitive therapy for PTSD was listed as second-line at the time of checking, whereas the guideline text and the official summary give it a strong recommendation **sources disagree; APA, 2017; APA, 2019; APA treatments page**. We follow the guideline text.

Medication and particular groups

Fluoxetine, paroxetine, sertraline and venlafaxine reduce PTSD symptoms in adults, but the improvement appears smaller than with the best-supported psychological treatments **proven by research; Bisson & Olff, 2021**. Results for military personnel and veterans are less impressive than for the population as a whole. NICE did not recommend EMDR for combat

trauma; Bisson and Olff suggest the small number and low quality of studies may have influenced this, so it reflects a lack of evidence rather than proven ineffectiveness (interpretation; Bisson & Olff, 2021).

Bisson and Olff call MDMA-assisted psychotherapy the most promising of the pharmacologically assisted approaches, but it was not included in the ISTSS guidelines **documented fact; Bisson & Olff, 2021**. It is an experimental direction, not standard care.

Chapter sources: Mavranezouli et al., 2020 · Davidson & Parker, 2001 · NICE NG116 · GPnotebook: NICE NG116 · APA, 2017, condensed version · APA, 2019 · APA: PTSD treatments · Bisson & Olff, 2021 · Lewis et al., 2020

Limits and open questions

Where these methods are weak and what specialists still argue about.

- **It is hard.** ERP and trauma-focused therapy ask people to tolerate intense discomfort. Some never start or drop out; in PTSD, dropout is higher from trauma-focused treatments than from other therapies **proven by research; Bisson & Olff, 2021**. Bisson and Olff caution that dropout should not be equated solely with tolerability; it has many causes.
- **Evidence quality in OCD** is lower than it looks: high risk of bias in most trials and few long-term results **proven by research; Wang et al., 2024**.
- **Poor insight.** When someone is almost certain their fears are real, treatment is harder and a psychiatrist is usually needed **clinical consensus; not verified against a specific source**.
- **Co-occurring problems.** Severe depression, suicide risk, psychosis, substance use and ongoing abuse need separate assessment and often a different order of care **clinical consensus**. For PTSD with depression, NICE advises usually treating the PTSD first, unless the depression is severe enough to get in the way of therapy **clinical consensus; NICE NG116, 1.7.1**.
- **Complex PTSD.** There is debate about whether a long "stabilisation" phase is needed before trauma work. NICE advises allowing more time to build trust, and other adaptations, for people with complex PTSD **clinical consensus; NICE NG116, 1.7.3**.
- **Religious obsessions.** Therapy targets only the compulsive part, never the person's faith **clinical consensus; not verified against a specific source**.
- **Culture.** The protocols were developed mostly in Western countries. Research on intrusive thoughts across six continents supports applying OCD models across cultures (interpretation; Radomsky et al., 2014); NET was developed for survivors in conflict zones and among refugees **documented fact; Infocop, 2019**.

Scales: what you can and can't use

Tool	What it measures	Can you use it yourself?
Y-BOCS	OCD severity; the main outcome in almost all trials	No: it is copyrighted and given by a clinician in an interview **documented fact; CamCOPS**
PCL-5	PTSD symptoms over the past month: 20 questions, total 0–80; a score of about 31–33 suggests probable PTSD	Freely available as a US government work **documented fact; CamCOPS; Center for Deployment Psychology**. It is a screen, not a diagnosis

A high PCL-5 score is a reason to see a clinician, not a verdict about yourself. Diagnosis is made in a clinical interview **clinical consensus; Center for Deployment Psychology**.

Chapter sources: Bisson & Olff, 2021 · Wang et al., 2024 · NICE NG116 · CamCOPS: Y-BOCS · CamCOPS: PCL-5 · Center for Deployment Psychology: PCL

Myths: a quick check

All the myths from these notes in one table.

Myth	Fact	Label
OCD is a love of order	Order is one theme; what defines OCD is unwanted thoughts and rituals that disrupt life	**Documented fact**
If I have frightening thoughts, I must secretly want them	93.6% of people have intrusive thoughts; the difference is how they are interpreted	**Proven by research**
You should keep reassuring someone with OCD	Reassurance is the most common form of accommodation and keeps the cycle going	**Proven by research; clinical consensus**
OCD can only be treated with pills	CBT with ERP is first-line; severe OCD is usually treated with a combination	**Clinical consensus**
Everyone who goes through trauma gets PTSD	WHO surveys suggest about 5.6% of people exposed to a traumatic event	**Proven by research**
You need to talk it through right after the event	Single-session debriefing did not prevent PTSD; NICE advises against it	**Proven by research; clinical consensus**
You shouldn't talk about trauma	First-line treatments work with the memory, in a structured way and with preparation	**Clinical consensus**
Time heals everything	About half of people with PTSD have long-lasting symptoms	**Proven by research**
PTSD only affects soldiers	Any exposure to threatened death, serious injury or violence can be traumatic	**Documented fact**
EMDR works because of the eye movements	A 2001 meta-analysis found no added effect of the eye movements	**Proven by research (2001 data)**

Try this: name it and wait

A one-minute exercise for people who get intrusive thoughts and the urge to check. It is a first step in self-observation, not treatment, and no substitute for a clinician.

Try this **One minute.**

1. When a "what if..." thought arrives and you feel the urge to check, name it to yourself: "This is an intrusive thought."
2. Don't argue with it, and don't try to convince yourself that everything is fine.
3. Put off checking for one minute and simply notice what happens to your anxiety during that minute.

The exercise rests on the same logic as therapy: anxiety can ease without the ritual. But it is not ERP; real exposure work is built together with a clinician.

Important **When to see a professional.** If rituals take more than an hour a day or get in the way of life; if you have lived for years with thoughts you are ashamed to say out loud; or if more than a month after a terrible event you still sleep badly, avoid reminders and startle easily, it is worth seeing a psychotherapist who works with OCD or trauma, or a psychiatrist. If you have been through trauma, don't do exposure to the memories on your own. If you have thoughts that you don't want to live, see If you need help now.

If you are a family member. With OCD, the best support is not "everything's fine" but "I'm here, and I believe you can handle this", following a plan agreed with the clinician. After trauma, it is not questioning but practical care and being ready to listen when the person wants to talk.

Check yourself

1. **How does OCD differ from perfectionism?** OCD feels alien and tormenting; rituals are done to prevent disaster or relieve an unbearable feeling, take up time and disrupt life. Perfectionism feels like one's own.
2. **Why does a ritual make an intrusive thought stronger?** It eases anxiety fast and is reinforced by that, but it stops you from learning that nothing bad would have happened anyway; the thought becomes more important and returns more often.
3. **In Salkovskis's model, what turns an ordinary intrusive thought into OCD?** Reading the thought as a sign of responsibility for harm, and then trying to neutralise it.

4. **How do the two explanations of exposure differ?** Emotional processing emphasises habituation and changing the "fear structure"; inhibitory learning says a new link is formed on top of the old one, and the key is an expectation that wasn't met.
5. **Why does NICE advise against debriefing?** A single talk soon after the event did not prevent PTSD, and in one trial the risk a year later was higher.
6. **In the Ehlers and Clark model, what creates the sense of threat "now"?** Negative appraisals of the trauma and the nature of the trauma memory, kept in place by avoidance, rumination and safety behaviours.
7. **Where do the guidelines disagree on EMDR?** NICE and ISTSS rate it first-line (NICE for non-combat trauma); the APA gave it a conditional recommendation in 2017.

Key takeaways

- Intrusive thoughts are normal; the disorder lies in the response to them.
- Rituals, avoidance and reassurance relieve anxiety for minutes and keep the cycle going for years.
- ERP is the core treatment for OCD; in severe OCD medication prescribed by a doctor is usually added.
- Family can help by offering agreed support instead of reassurance.
- BDD and hoarding share the logic of checking and avoidance; CBT with ERP works well for BDD, more modestly for hoarding.
- Most people recover after trauma; for persistent symptoms trauma-focused treatments help: CPT, CT-PTSD, PE and EMDR.
- Straight after an event, practical support and monitoring help, not a compulsory heart-to-heart.
- The evidence is strong but not flawless: look at the caveats, not just the big number.

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