**Audio Transcript for Episode 504: "Delay, Slow, and OCD" with therapist Sara Galaglo**
*Please note: This transcript has been lightly edited to remove filler words or sounds.*

**SARA GALGALO:** If I'm giving like a mantra or word to the individual who has OCD, 'slowly" or "delay" can be really great ways to sort of hold on to that idea of "This is how I want to try to respond to my anxiety in this moment. I want to try and delay how quickly I'm going to respond to the urge to do this compulsion and see if I can tolerate the discomfort a little bit before I engage in it."

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**CHAD MOSES:** You're listening to the To Write Love on Her Arms podcast, a show about mental health and the things that make us human. I'm your host, Chad Moses. And in each episode, we'll be talking about the things that can often feel hard to talk about, like depression, addiction, self-injury, and suicide. We'll be sharing stories and exploring big themes like hope, healing, and recovery. If any of the topics we discuss or the stories we share feel too heavy for you, know that it's OK to pause, to restart, or to stop altogether. As we discover new stories, we hope to remind you that your story is important.

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**CHAD**: Candance wrote, "Parts of my brain continually struggle for power while others retreat completely. But no matter what's been taken—time, control, hope for the future—it's never too late to start anew."

Bianca said, "Every day I learn new things about how my OCD manifests, and I am figuring out in real-time what that means for my relationships, health, and job."

And Kirsten shared, "OCD, contrary to popular belief, is not tidy or clean. It's messy. Exhausting. Loud."

These words come from personal experiences with Obsessive Compulsive Disorder, stories we've had the honor of sharing on our blog. But OCD is not a challenge we've talked about on this specific platform.

So today, it is our honor to have Sara Galgalo, a psychotherapist who works at the OCD Center of Los Angeles, as our guest to help us better understand OCD, how it gets misdiagnosed for other things like anxiety, and the type of treatment that is having a pretty incredible impact. Outside of work, Sara is a big Doctor Who fan. She grew up playing sports and was even a figure skater for years, and she loves to go hiking back in her home state of Washington.

With all that being said, we've got a lot to cover. So let's get started.

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**CHAD**
So here we are. Well, first, Sara, I guess would you mind just giving us a brief overview of the OCD center of LA?

**SARA**
So the OCD Center is a private mental health practice that specifically specializes in treating OCD and other related anxiety or OCD spectrum disorders. So we specifically use a mindfulness-based Cognitive Behavioral Therapy with an emphasis in gradual exposure and response prevention. It's a lot of words, I'm sure at some point, I'll probably explain what they all mean. But we use behavioral therapy, specifically to treat OCD and anxiety disorders.

**CHAD**
So for the astute listener, you'll be aware that this is the first time on the podcast that we have spoken intentionally and expansively about Obsessive Compulsive Disorder. With that in mind, Sara, could you start by giving us in our listeners a brief introduction into what OCD is, how it presents and how common, how prevalent this mental health challenge is?

**SARA**
I guess I'll just start with what OCD is specifically comprised of. So in order to receive a diagnosis, there's sort of three key features that we're looking for. One being that the individual is experiencing an obsession, right? So in that you're having intrusive persistent thoughts, feelings, sensations, impulses, or urges that you don't want to have, that are distressing to you. Right, so that's the first sort of component. The second component is that you are engaging in compulsions to remedy or resolve the distress that's being brought up from the obsession. So there are a variety of types of compulsions. A behavioral compulsion, which is what most people think of. So if you have anxiety about driving, right, and you worry that you might have hit someone. Someone might actually physically check their car, get out and like look at their car or circle the block. Like if there's something that you are actively doing. That's what would sort of fall under the idea of physical or behavioral compulsions. People also engage in avoidance, that would also be considered a compulsion. So if there are things that you're not doing for fear that it might trigger anxiety, or trigger intrusive thoughts, that would be compulsive. Reassurance-seeking is a really big compulsion as well. So if you're asking people for reassurance that things are okay, that things are fine, that you're safe, right? That would be compulsive. You can also, the other version of this because we live in a world where technology exists, is you Google. If you're doing a lot of online research, you're searching Reddit forums, you're on WebMD, you're reading articles. And then the final compulsion that I think people don't often recognize would be mental compulsions. Because OCD is generally viewed as being something that's really external, people don't often realize that the majority of the clients that I've worked with actually experienced mental compulsions. So what that basically means is the rumination, but like specific ways that you might ruminate that are in response to the obsessions that you're having. So the obsession you can't control. But the mental compulsion is generally the response that you're having to the obsessive thoughts.

**CHAD**
So as you're walking through that, definitely in my mind, I'm having these big questions of prevalence. Are there any reliable statistics out there that can inform us as far as what's the percentage of the population that lives with this?

**SARA**
So the last key factor in terms of diagnosis that is going to be relevant that goes into statistics is really that you can have those experiences of having obsessions and compulsions, but it needs to impact and affect your life in a significant way. It needs to take away, like, it requires that you are engaging in those obsessions and compulsions for hours, right? And it's negatively detracting from different parts of your life. So in terms of how prevalent it is, I'm quoting this number specifically from the International OCD Foundation, and in terms of what numbers that they provided, it's one in 100 adults in the US. That looks like two to three million adults are diagnosed with OCD. And then when it comes to teens and children, it's about one in 200 for children and teens. So that's about half a million children and teens that are diagnosed with OCD specifically. I read somewhere in a book recently that OCD is like the fourth most common diagnosed disorder in the United States. So it's quite prevalent. In general, anxiety disorders tend to be quite prevalent and quite common in terms of diagnosis.

**CHAD**
As you were walking through some of the different buckets of what comprises OCD, I couldn't help but you know, kind of walk through my own life's journey of times where some of what you're describing felt familiar. And as someone that is not and has not been diagnosed at this point in my life with OCD or obsessive compulsions, and I think it's important that we're talking a little bit before this interview began about this idea that it's not binary. It's not all or nothing, but there is this evolving language of obsessive-compulsive spectrum challenges. Would you be able to illuminate that a little bit more? When we say OC spectrum challenges what are we really talking about?

**SARA**
In general, I think when you look at what what psychology has typically viewed OCD and mental health disorders, it's really been quite segmented. I would say that me and a lot of my colleagues tend to view anxiety in a in a much more collective sort of beautiful mix right? Like, there's not very much in terms of treatment difference between how I'm approaching OCD versus social anxiety versus health anxiety. So all of these things are actually more similar than dissimilar. And so when you're looking at the spectrum of obsessions and compulsions or OC spectrum as you mentioned, what we're including and what we're thinking about is BDD, it’s hair pulling and skin picking, excoriation and trichotillomania. It's health anxiety, it's phobias, it's OCD. It's a lot of these different things. And even within that spectrum, people vary in terms of severity. The majority of the clients that I see are going to be at a clinical level in terms of diagnosis. But I've also seen plenty of people who don't necessarily meet clinical criteria, but have enough anxiety where it is distressing to them, and it is bothersome to them. And these

skills are also just helpful in teaching you ways to tolerate thoughts and feelings that are distressing.

**CHAD**
As we lean into, and as we imagine and kind of wrap our minds around specifically the non physical manifestations of OCD, with you're talking about mental OCD, to what degree are some of these compulsions directly linked to an experience? Perhaps it's unfair to ask that question, you know, knowing that there is such a breadth of experience of OCD. But in your experience, have you seen a correlation between a traumatic episode or a traumatic event, and how that manifests into disordered thinking or disordered action down the road?

**SARA**
That tends to be actually less common, right? It's not that it's uncommon at all but that it just tends to be less common. Yeah. So I have seen clients who've had some sort of traumatic event that leads to a phobia, that leads to them having social anxiety or a specific phobia in general. But when I'm working with the majority of my clients, they typically have sort of like a variety of experiences, the two most predominant tend to be that they've either had OCD or anxiety for the majority of their life. It began sometime in childhood, that's really an experience that they can recall for the majority of their life. Or it became more singularly predominant in young adulthood. So if it's around like high school, or around college, or post-graduation, that tends to be a time where people often see a flux or an increase in OCD or anxiety symptoms. There's often a correlation in the sense of people having family history, so there might be also a genetic component. Or it might not be. If they're adopted, this has happened too, but their adoptive parents have OCD. So it was modeled and it was learned, so that tends to be common too as well. But in general, in terms of presentation and how people develop OCD, it tends to sort of come into those two points of onset.

**CHAD**
You hinted at this a little bit earlier about how OCD symptoms can line up, can kind of double dip with a number of other mental health challenges. You mentioned, specifically, anxieties and phobias. And this, of course, can easily lead into a realm of misdiagnosis or maybe delayed diagnosis. On average, how long does it take to accurately get a pulse on this, to accurately diagnose OCD? And what are some of the most common confusions?

**SARA**
I think the average was that most individuals with OCD, on average, see about like seven other therapists before they get the right treatment. That's what I heard from the IOCDF. What they claim is that from the onset of symptoms, it takes about 14 to 17 years before people are able to get adequate treatment and proper treatment for OCD and anxiety. So it can be a long time. In terms of our understanding for OCD, a lot has changed and a lot has evolved. But yeah, 14 to 17 years tends to be the average between people experiencing symptoms and then accessing treatment or proper treatment. Barriers to that, you're right, are misdiagnosis. I have a lot of clients that are often diagnosed with having generalized anxiety but the therapist not necessarily understanding that they actually have OCD. In terms of what can get in the way of that, I think

there's a lot to be done in terms of education within the therapeutic community and the psychological community about what OCD looks like, because I think a lot of therapists are very, very misinformed. But if you're also talking about what mental health disorders does OCD often get confused for, there are definitely an array. And so a big one, if you have something like a repeated physical behavior, people might get that confused with tic disorder. But there's a difference. So if you have tic disorder, the behavior is viewed as being a little bit more automatic. Whereas with someone with OCD, it's a lot more intentional. If they're engaging in a physical behavior it's intended to resolve anxiety, right? So there's more choice and intention behind that compulsion.

**CHAD**
That's a super important thing to maybe return to, is just kind of the causality. The internalized desire for coping to address an anxiety. Did I understand that correctly?

**SARA**
Exactly. You might see that the behavior is the same, but the reason for going about it is going to be very different, and the experience part will be very different. This is also true for impulse control disorders. So, if you think of like gambling, addiction, sexual addiction, shopping, compulsive like shopping, right? The intention behind those behaviors are going to be really different. For something like an impulse control disorder, right, you're doing those behaviors specifically to experience more of a feeling that you view as being positive. Whereas individuals with OCD are intentionally trying to get away from feelings that are distressing to them. So you might find that they're doing things in a way that's impulsive, but they're impulsive for different reasons.

**CHAD**
This opens up such an important window into language. And I hesitate to go there immediately. But I don't want to lose this train of thought. This idea of so much of OCD vernacular was gifted to us through improper teachers, right? Through jokes, through quote unquote “comedy,” through these characterized renditions of what an actual OCD disordered lifestyle looks like. So with that, you know, you were just doing so well to parse language and intention, and that brings to mind that it is not the job of everyday folk to go about diagnosing a friend, a family member, a stranger, a classmate, a coworker, even someone that we see on TV, a media personality. Like, it's not in our wheelhouse to go about and say this is x or this is y. And again, that runs the risk of doing more damage in the long run. You mentioned the need to continually and intentionally educate the therapeutic community, because even the folks that are looking to help may have had the wrong idea passed on to them along the way. So I want to make sure we properly address the previous question of where do you see the most common misdiagnosis? What do you see most frequently mislabeled and in this realm?

**SARA**
I think if you're asking for my own personal experience, what I see happen a lot, generalized anxiety is often a diagnosis that I see come up a lot. And that's not that's not to fault anyone, like I would say a lot of my clients with OCD probably also meet criteria for generalized anxiety. But

the content of their thinking is a little bit more irrational in the sense of the subject matter. It's a better fit under OCD. And I think the approach to treatment looks a little bit different. I think you have a lot of people that might say that they specialize in treating generalized anxiety and use a lot of different approaches to treat it because they think it's just typical, everyday anxiety. And I think that that's why people often miss out on accessing appropriate treatment, is because they think it's just OK, it's just like typical anxiety. The other thing that I think is thrown out there a lot is bipolar disorder, that happens a lot. Part of it is the fluctuation of emotion. People don't often note the correlation between OCD and depression. That's really, really common. Most of my clients experience that. So they can go from being in spaces where they're really distressed, right, and their body reaches some sort of cap where they can't, they just can't manage it. And so they'll switch into this state of depression. That's normal for them to go back and forth. If you're communicating that experience to a therapist, and they're hearing that there's a mood shift, they can often and have often diagnosed someone with bipolar disorder, when really there's a better fit with OCD. The other one that sometimes gets thrown out there, not as commonly, is schizophrenia. That doesn't happen as often. But it does happen every now and then. And that happens often, especially if you have, like, more of the Pure O type of thoughts. Especially things around like harm or sexual thoughts, I think they tend to get misunderstood a lot more, because the content seems a lot more negative and a lot more scary to other people who don't understand. For someone who has a psychotic disorder or has schizophrenia, their experience with their thoughts are different. They might view their thoughts as being real, right, not understanding that they're not a reflection of what reality is. They're buying into it. Whereas someone with OCD is going to have those thoughts but also understand that it's not real. They're going to understand that it's irrational. And so their experience of reality, they might be engaging in their fear as if it's real, but also understanding that it's not.

**CHAD**
As we acknowledge the reality that misdiagnosing can and does happen, we know that that treatment is going to look different from pain to pain, from disorder to disorder, from what you need on a day-to-day basis. So as someone that has worked in a very intentional, in an intimate way with the OCD community–specifically at the OCD Center of LA–you know a lot about treatment modalities, about how to go about addressing a promise. It's one thing to name a problem, it's another thing to figure out, "What are the plans to go about addressing it?" In what ways does treatment for OCD differ from more commonly-known and -occurring mental health challenges such as depression, like you mentioned, or general anxiety disorder? And in what ways is OCD and treatment for overlap with other mental health challenges? I think it's fair to acknowledge that you can be more than one thing you can have more than one experience. So it's totally possible to have co-occurring disorders that deserve the treatment.

**SARA**
So if we're comparing the difference between treatment, from how we approach treatment for OCD and anxiety disorders and everything else, I think the central key factor of what's going to make it different is exposure and response therapy. You might find that there are a lot of different, like, if you're treating emotion dysregulation or borderline personality disorder, you're going to find that DBT is going to be the central sort of treatment for it. If you are treating

depression, you're going to find that the treatment for depression is cognitive behavioral therapy. But that CBT looks different, a little bit different than the CBT that we use, right? So the bigger difference being that we use Exposure and Response Prevention. And just to do a little bit of education if you guys are curious, Exposure and Response Prevention is a type of behavior therapy that involves us specifically creating a hierarchy. Which is basically a ranking of what your compulsions are and what triggering situations would be, and rating them from least anxiety provoking–and that could be like, if you're at a zero or one, like, super chill. That's what we start with. And then all the way up to a 10, which would be whatever you would think would trigger a panic attack for you. And we gradually have people engage in these behaviors, or disengage from behaviors if they're doing compulsions, so that they can, over time, develop the ability to tolerate distress and be more capable of handling thoughts or feelings that would typically be really, really distressing or anxiety-provoking for them.

**CHAD**
I love the idea that different challenges will, of course, mandate different types of treatment. So I think it's important in the case of this conversation with OCD. And I really liked the idea of exposure therapy being applicable to people beyond the spectrum of OC disorders. And it's almost like, if you have this goal to run a marathon, it's gonna take more than just, you know, you're not going to hit it on your first trip on the treadmill, right? You're gonna have to find ways to build up. You're gonna have to find a good coach, a good community around you to give you different perspectives and to increase these thresholds as we approach our goals.

**SARA**
Yeah, I totally agree with that. I think understanding that different styles of therapy are different ways to approach change and they have different ways that they go about that. With something like psychodynamic talk therapy, insight is going to be the key generator for what change looks like in understanding. That's how we're going to have insight for how to do things differently and we can make change that way. With behavior therapy, it's really specific about breaking down what change looks like in small pieces and small steps and that can be applicable to a lot of different things. Which is why I think, in general, this style of therapy is really great. I don't think it has to be limited to people who have OCD or have anxiety disorders. It can be really sort of expanded to a lot of different things, right? Like if you want to take on this approach of really gradually working up to doing something that's hard, it's going to be valuable for everyone. And I think this process of therapy really does change the way that people look at the process of change. Because I think we do have a tendency to have really unrealistic expectations about what that looks like and we expect immediate results. And we can be quite perfectionistic about what things need to be like, how things need to happen, that we can get in our own way of being able to move forward.

**CHAD**
Yeah, I love that idea of being able and empowering people to find the winnable battles that you can set yourself up for an easy win from time to time, and there is no shame in doing that. That's not an easy way out. You're not cutting any corners there. But you're learning, every step of it is a learning process. You deserve the ability to look back on the day and say, you know, “It

doesn't have to be binary." It doesn't have to be, "This was the worst day ever" or "the best day ever." But it could be, "I knew that I was able to apply a new thought pattern for this. And I feel good about the progress being made."

**SARA**
There's such value in celebrating the things that we do really well. Because I think in general, we all have the same bias to fixate on what goes wrong and really dismiss everything that we do well, or that we worked hard at, even if we didn't necessarily attain the result that we wanted. If we made the effort to really work towards something, right, we can celebrate. We can celebrate that. And I think in a lot of ways, that's something that we can dismiss. And it's something that I definitely encourage my clients to acknowledge and also help them celebrate all of the small wins that lead to the bigger, bigger wins that they want.

**CHAD**
I love that. And what you just said is, man, slap that on a billboard.

[music playing]

**BECKY EBERT**
Hi friends. Becky Ebert here, TWLOHA's editor and producer. I just wanted to take a moment to tell you about an incredible partnership we're doing with Dock & Bay. If you're not familiar with them, they're a sustainable lifestyle brand that uses 100% recyclable materials to create beach, home, and beauty products. And right now they've got an exclusive beach towel in collaboration with Smiley Movement where 20% of all sales are being donated to TWLOHA! You can go and find that towel and other items by visiting dockandbay.com. And if you're a new customer, you'll also receive 10% off your first purchase, too!

[music playing]

**CHAD**
And now is the part of the conversation that I have been looking forward to the most, which is this piece about language. I, you know, preemptively tried to get there too quickly when there's so much more foundational work to be done. But in the past 10 years, or maybe even more recently, even in the past five years, well, maybe even more recently than that, perhaps even today, people will throw around terms like OCD as a means to describe someone who's tidy, who's precise, who's organized. This idea that language across the world of mental health is often given to us by teachers who maybe didn't want to be teachers in the first place. And, you know, for example with sitcoms, with media, with books, they're really good at entertaining. They're less good at educating in deep and profound ways about mental health challenges. So as it relates to just language regarding OCD, and how it is often utilized, can you talk about how this inaccuracy in language can present really, potentially severe problems? Misguiding forces that we now have to combat above and beyond the actual disorder that we're living with.

**SARA**

When people use the sort of the phrasing around OCD in such a casual way, like “That's so OCD” or “You're so OCD,” it's quite dismissive. And I think for a lot of people, the pain that it presents is that it's erasing their lived experience with OCD. There's a very specific sort of idea when people think of OCD. There's generally an image that people have about what that means. And typically that's been contamination obsessions, safety-related fears that involve a lot of checking doors, checking stoves. And that is still OCD. But I think in a lot of ways, what I found to be true is that a lot of the individuals who have more of what we call, it's a myth. It's not actually Pure O, because it's not just purely obsessional. But in the in the Pure O-type theme where you have morality- or scrupulosity-related obsessions, if you have sexual obsessions, harm obsessions, I think that their experience tends to be erased or not acknowledged. And I think when people really talk about that in a really sort of casual way, it can be quite dismissive. One, to their experience, because it's not just tidiness. But two, it's also dismissive in the sense of like, how painful and how debilitating OCD can be. Like, at its worst, it can really corrode and eat away at people's lives. And so when people use it in such a flippant way it is hurtful because I do think that it doesn't speak to how emotionally challenging and difficult it can be to have OCD. So that's one part.

**CHAD**
And I'm imagining right now, especially for young people, for school-aged individuals that may be starting a journey with OCD and already you're feeling unsure about social interactions, your place in the world, and all of a sudden you're dealing with a disorder that you didn't ask for. To have a mentor, to have a parent, perhaps, to have someone else in your life to prescribe such a trite and inaccurate treatment strategy of. “Oh, well, you can stop that anytime.”

**SARA**
“Just don't think about it.” Yeah, the number of times that clients have said that to me “Yeah, my parents told me that I just shouldn't think about it anymore.” It's like, well, how's that working? It probably isn’t effective to just not think about something. But it goes into a lot of other stuff where I think we have a very–this is a side note, but like–I think we do have a very unrealistic expectation around what thoughts and feelings are like, and what we can do, or how we can respond to them that's not true. Because I think a lot of people just believe you can just not think about it. It's like, “Well maybe you can. But that's not something that someone with anxiety or OCD can do.”

**CHAD**
That's just human nature, right? We talk about it all the time. You know, “Don't push this button. Under no circumstances, push this button.” And now the only thing you're going to be thinking about is pushing the damn button. And so everyone, to a degree, has to take a step back and realize that thoughts are things that just happen, thoughts occur. You don't choose your thoughts at all hours of the day–dreams being a great example of that. Like, your brain is a ceaseless machine that is constantly trying to throw information at you, oftentimes to protect you. And this is a question that I often talk about to people with lived experience, and also with people with experience in treatment and care. Where, if anywhere, have you seen accurate and compassionate depictions of Obsessive Compulsive Disorder? Through literature, maybe

through storytelling, or songwriting, or anywhere out there that you think, “Yeah, they get this. Yeah, that's a safe place.”

**SARA**
I've heard clients really resonate with the book *Turtles All The Way Down*. I've had clients really also resonate with the show Pure. It's a British show and it centers around this girl who realizes that she has sexual orientation OCD. I think it's supposed to be her journey to discovering it and then accessing treatment. And it's based off of a real person, I think, who wrote a book. Those two things in media have often been things that people have really connected and resonated with in real ways. In terms of literature, as far as actual psychotherapy book, I tend to be quite specific in what I recommend because I think a lot of literature that is from a therapy space can be quite clinical. So I get it, but sometimes the everyday person doesn't always get it. And so a book that I really do recommend, because it's not specific to OCD, it's really open for mental health in general, is *The Happiness Trap* by Russ Harris. Great book, I love that book. He also has a picture book version. If you really don't want to read a book, he has a picture book version. So you can look through it that way too, as well, which I love.

**CHAD**
A hero of the millennial mental health community is John Green, who wrote *Turtles All The Way Down*. Absolutely. So let's backtrack a little bit to the beginning. What was mentioned was this idea of cognitive behavioral therapy, and that being a modality that you have employed and that you have seen some real successes. I'm wondering if you would be comfortable, if you'd be able, to offer a word of advice or maybe even a mantra for someone or on behalf of someone who deals with OCD, or another obsessive-compulsive spectrum challenge?

**SARA**
I don't typically give very many mantras away. But if there's a central idea that I would call a person to be grounded in, in terms of being rooted in this type of response, I tend to go into different directions depending on the person. One might be “Slowly,” like if I'm thinking of a word, it might be grounded in “Slowly.” There's a lot of urgency that a lot of people with anxiety disorders experience. And so there's a lot of value that can be gained in just, like, slowing your own response. It also helps you be more rooted in a mindful way, too, as well. Mindfulness being something that we utilize to help people be more present, which is hard to do. It's really hard to do if you have OCD or an anxiety disorder. The other would be delay. We talked about how nuanced change can be. And it's not really “all or nothing.” And sometimes the beginning of what change can look like can just be delaying a compulsive behavior. So if I'm talking to the individual, if I'm giving like a mantra or word to the individual who has OCD, “slowly” or “delay” can be really great ways to hold on to that idea of, “This is how I want to try to respond to my anxiety in this moment. I want to try and delay how quickly I'm going to respond to the urge to do this compulsion, and see if I can tolerate the discomfort a little bit before I engage in it.” And viewing that also as a win. Because people don't see that as success, that that would be success if I delayed how quickly I responded to the compulsive urge. Because all you're doing is increasing the delay time, over time, to the point where you might not even need to engage in a compulsive behavior at all.

**CHAD**
I love it. Delay. And slowly. There's still some time.

**SARA**
And it's hard. It's hard. Like, “slowly” would be just as much of an exposure as “delay” would be because we feel called to respond to something that feels life or death. That's how it feels. And so to not engage in the moment is a challenging thing to do. So if you can practice just trying to slow down what it is that you're in at that moment, if you have the opportunity and the ability to do it. It's something that you should.

**CHAD**
Yeah. I guess to end this, we know that someone can struggle with OCD without being diagnosed with OCD. This is our way of acknowledging the caretakers, the people, the friends, the family of those who love someone living an obsessive-compulsive pattern of life. What advice or encouragement would you give to a person who's supporting a loved one who's living with OCD?

**SARA**
If necessary, seek out resources, support, and therapy. Depending on what their level of severity in terms of OCD is, there might be a lot that you're coping with and managing to try and support them. And I think not being, it is completely fine to seek out your own treatment so that you can adequately support that individual. I think, if your loved one is actively dealing with a therapist, right, who does specialize in treating OCD, I think from there you get to have conversations about, what are the ways in which–if you're involved in their OCD–that I can disengage, that I can appropriately support this person that I love and care about, without enabling and engaging in their OCD. Because I think a lot of times we try to provide comfort. And with OCD, it's a little bit different, because in that regard, we might be engaging in compulsive behavior with the person that we love, right? And we might be inadvertently contributing to that obsessive and compulsive cycle. So learning what are the ways that we're doing that with support and conversation, right, learning to practice disengaging from those things. There are resources and community that you can connect to for support if you're a loved one. They may not always be, accessibility and being able to access treatment and support for OCD is different, obviously, depending where you're located. Especially if you're not in a city, it's harder to access care. So it's getting connected with larger communities, following people on Instagram or on social media that really do speak to the experience of a loved one. If they’re a loved one or the caretakers for someone that they love as OCD, that's often like a good thing. And reading literature.

**CHAD**
Where loving a family member or loving a friend is intuitive, caring for a friend or a loved one or family member is not necessarily intuitive. So yes, lean into the educators, lean into the literature, lean into the support groups.

**SARA**

Community is a lot more strengthening. Because it can feel really, it can feel really isolating, it can feel extremely overwhelming. And having support and having guidance, if it's from a peer support group or if it's from a therapist, is going to help you do the things that you need to do to support your loved one. Because it's hard not giving what feels like comfort, if a therapist is able to identify that it's compulsive. It's hard not doing it because, instinctually, we all want people to feel better. And so not not engaging in that is a hard thing to do. So having support systems that are encouraging you to do that, you're able to communicate with your loved one, and also have a gradual approach if that works for them, right, where you can withdraw reassurance or engaging in certain compulsions gradually, that's a good thing. And it protects relationships, right? Like if your overall goal is to stay in connection in these relationships, these are going to be good things that protect those relationships overall, as well.

**CHAD**
Sarah, this has been such an incredible conversation. And again, thank you so much for being generous with your time, with your wisdom, with your insight. If there's anything that we haven't covered, that you wish we would have, now is the time.

**SARA**
I think the one thing I would've probably mentioned, just to also land on a bit of hope, is that if you do have OCD and you have anxiety, it is extremely treatable. Like, it's extremely treatable. You can find a significant reduction in terms of the intensity of your symptoms by doing therapy. This therapy is groundbreaking for OCD and for anxiety. And in essence, a lot of what we're doing this speaks to a study–I'll go on a tangent, I guess. But in the, I want to say it was in the 90s over at UCLA. They did a study where they did brain scans for individuals before treatment with OCD and post-treatment. And what they were able to find was that in doing this work, in doing cognitive behavioral therapy–along with also receiving support through medication–fundamentally in a huge way, they were able to see differences in their actual brain activity. This work is phenomenal in creating change and changing your experience with anxiety. So if you do have anxiety and you do have OCD, seeking out appropriate treatment can change your experience with OCD and anxiety to the point where–it might still be there because you might still have intrusive thoughts–but it won't impact your life in the way that it is at this moment. You can find significant relief in being able to do this work.

[music playing]

**CHAD**
We want to express a genuine thank you to Sara for imparting her seemingly endless wisdom and guidance. As conversations like this one allow our own team to learn and grow, we hope you feel leaving a bit more informed, a bit more aware, and a bit more seen and cared for. Mental health challenges, like OCD, have a way of making us feel incredibly isolated and hopeless. But knowing there are folks out there who understand and who know how to help is truly perspective-altering. So regardless of whether you can relate or are simply tuning in for the sake of learning, we're glad you're doing just that. And as always, we're glad you're here.

[music playing]

**CHAD**
We hope this episode has been a reminder that your story is important, you matter, and that you're not alone.

If you're struggling right now, know that it's OK to reach out and that there are people who want to help. Part of our mission is to connect people to the help they need and deserve. You can find local mental health resources on our website, twloha.com. That's T-W-L-O-H-A.com. And click FIND HELP at the top of the page.

If you're in the U.S. or Canada and need to talk to someone right now, you can always text our friends at Crisis Text Line. Simply text the word TWLOHA—again, that's T W L O H A—to 741741. You'll be connected to a crisis counselor. It's free, confidential, and available 24/7.

For a list of crisis support resources for our listeners outside the United States, please visit twloha.com/find-help/ and click on the International Resources tab.

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A big thank you to our friends at Copeland for the original music on this episode. The To Write Love on Her Arms podcast is produced by Rebecca Ebert. Music assistance was provided by James Likeness and Ben Tichenor.  And again, I'm Chad Moses. Thank you so much for listening. We're glad you're here.