OCD and Neurodivergence

Compassion, Autonomy and Supportive Strategies

Session notes from guest speaker Anna Sackley

Names and identifying details from community contributions have been removed or generalised to protect privacy.

Important note

These notes are for psychoeducation and community reflection. They are not medical advice, diagnosis or a replacement for personalised support from a qualified professional. OCD, eating disorders, trauma, self-harm risk, medication and mental health crisis all need individual support. If someone is at immediate risk, contact emergency services or urgent mental health support.

1. Session overview

This session explored OCD and neurodivergence through lived experience, family learning, neurodivergent-affirming practice and compassionate support. The main message was that OCD should not be framed as a "bad part" of a person that must be crushed. A more helpful frame can be seeing OCD as an overprotective part of the brain trying to create safety, certainty or control.

The session highlighted that many Autistic, ADHD and PDA people experience existing approaches to OCD support as too rigid, too high-demand or too shame-based. This can make people feel that they are failing at therapy, when in reality the support may not have been accessible or properly adapted.

Key themes

- Moving away from "white knuckling" and pushing through distress without enough support.
- Understanding OCD as a safety-seeking loop rather than a personal flaw.
- Recognising the overlap between OCD, trauma, sensory needs, PDA, anxiety, burnout and executive functioning.
- Using compassion, autonomy, scaffolding and pacing instead of shame, force or sudden removal of support.
- Naming the OCD pattern and taking very small steps towards change when the person feels safe enough.

2. What does it mean to move away from "white knuckling"?

"White knuckling" means forcing yourself through distress by gripping on, masking, suppressing, enduring, or doing what you have been told to do, even when your nervous system is overwhelmed.

In OCD support, white knuckling might sound like: "Just stop doing the compulsion," "Don't ask for reassurance," or "Push through the exposure." For many neurodivergent people, especially those with PDA, trauma or burnout, this can feel unsafe, demand-heavy and unmanageable.

Moving away from white knuckling does not mean avoiding all change forever. It means making change safer, smaller, kinder and more collaborative.

- What support would make this feel safer?
- Can this step be made smaller?
- Can the person have more choice and control?
- What is the OCD trying to protect against?
- What would compassion look like before we ask for change?

3. OCD as an "overprotective friend"

A powerful idea from the session was to describe OCD as an "overprotective friend". This does not mean OCD is harmless or easy. It means the language shifts from battle, shame, and crushing parts of ourselves to understanding, compassion, and the gradual reassurance of the nervous system.

Instead of "OCD is a monster I must defeat", the speaker described an approach closer to:

- OCD is part of my brain that thinks I am in danger.
- It is loud because it is trying to protect me.
- I do not need to crush it; I need to show it gently that it can step back.
- Tiny steps, repeated with compassion, can help the OCD become smaller and quieter over time.

This approach can help reduce shame, especially for people who take language literally or feel distressed by the idea that part of them is "bad".

4. How OCD can show up for Autistic, ADHD and PDA people

OCD can overlap with neurodivergent experiences in ways that make it harder to identify. It may be tangled with sensory overwhelm, routines, sameness, uncertainty, trauma, masking, burnout, interoception, executive functioning and the need for predictability.

Autistic people

- OCD may become linked with sensory distress, "just right" feelings, contamination fears, ordering, sameness or emotional safety.
- A routine may start as a regulation but become OCD-like if the person feels terrified or unsafe when they cannot do it.
- Emotional contamination may attach to places, objects, clothes or memories connected to trauma or distress.

ADHD people

- Working memory difficulties can create genuine uncertainty: "Did I lock it? Did I send it? Did I turn it off?"
- This can become a checking loop when the check never feels enough.
- Completion compulsions may attach to task-switching difficulty, unfinished tasks, mistakes or fear of forgetting.

PDA people

- Rigid therapy tasks can feel like demands, even when the person wants help.

- A direct instruction such as “do not do the ritual” may trigger threat, shutdown, refusal or panic.
- Support often needs to be indirect, choice-led, collaborative, flexible and autonomy-respecting.

5. Emotional contamination OCD

Emotional contamination OCD is when a person feels contaminated not only by germs or dirt, but by an emotional association. An object, place, item of clothing, person, room, smell or memory may feel “unsafe” because it is linked to a distressing or traumatic event.

Examples might include:

- An item of clothing feels unsafe because it is linked to a difficult time.
- A room feels contaminated because something distressing happened there.
- A school bag, car seat or doorway feels unsafe because it connects to school trauma.
- The person feels they must wash, avoid, replace, repeat or clean to remove the emotional feeling.

The International OCD Foundation notes that emotional contamination can include magical thinking and superstitious behaviours, where the person feels that an association carries special danger or power. In neurodivergent people, this can become intertwined with sensory memory, trauma memory and pattern recognition.

6. Accommodations, scaffolding and safety

A major theme of the session was that accommodations should not automatically be treated as “feeding OCD”. For some neurodivergent people, accommodations are the scaffolding that allows them to stay safe enough to function.

Scaffolding might include practical support, co-regulation, adjusted communication, reduced demands, environmental changes, sensory supports, or supporting a person to access care in a different way.

The key is that scaffolding is not assumed to be permanent. It helps the person feel safe enough to stabilise. When they are ready, supports can be reviewed gently, collaboratively and without shame.

Scaffolding questions

- What does this person need right now to reduce immediate distress or risk?
- Is this support allowing basic functioning, safety or dignity?
- Can we name it as temporary scaffolding rather than failure?
- When the person feels safer, which tiny part could be adjusted first?
- Who gets to decide the pace, and how can the person have autonomy?

7. Naming the OCD and using the “purposeful pause”

One practical strategy discussed was naming the OCD pattern. Naming can reduce shame and create distance: “This is an OCD fear,” “This is the overprotective part speaking,” or “This is the checking loop starting.”

Another strategy was the “purposeful pause”. This means not trying to stop the compulsion all at once, but creating a tiny gap before responding. The pause might only be 5, 10 or 15 seconds at first.

For example:

- Pause before offering reassurance.
- Pause before repeating a ritual.
- Pause before checking again.
- Pause and say: “I can feel the OCD asking for certainty.”
- Then decide whether to respond, delay, reduce, or ask for support.

For some people, this tiny pause may be a more accessible first step than trying to fully resist a compulsion.

8. Exposure therapy and ERP

ERP stands for Exposure and Response Prevention. It is a form of CBT where a person gradually faces feared triggers while trying not to complete the compulsion or ritual. NICE guidance recommends CBT, including ERP, as a key treatment for OCD, with treatment intensity depending on the level of functional impact.

The session recognised that ERP can be helpful, but also that it can be inaccessible or harmful if delivered in a rigid, shame-based or high-demand way.

ERP may be more neurodivergent-friendly when it is:

- Collaborative and consent-based.
- Slowly paced and broken into tiny steps.
- Linked to the person’s values and real life, not abstract tasks that feel meaningless.
- Sensory-aware, trauma-informed and PDA-aware.
- Supported by co-regulation and autonomy.
- Willing to use creative, organic exposures that arise naturally in everyday life.

ERP can feel unsafe when it is:

- Forced, rushed or presented as “just stop doing it”.
- Based on shame, punishment or “beating” the OCD.
- Delivered without understanding autism, ADHD, PDA, trauma or sensory distress.
- Focused only on removing accommodations, without understanding why they are there.

9. Differentiating “Just Right” OCD from autistic sensory needs and routines

This was answered in the session and is one of the most important overlaps to understand. The same outside behaviour can have a very different inner experience.

Question to ask	More likely autistic need/routine	More likely OCD compulsion
What is driving it?	Regulation, sensory comfort, predictability, identity, clarity.	Fear, dread, threat, guilt, “something bad will happen”.
How does it feel?	Calming, grounding, pleasing or organising.	Urgent, distressing, never enough, panic-led.
What happens if interrupted?	Dysregulation, frustration, sensory overwhelm.	Panic, catastrophic fear, intrusive thoughts, guilt or danger.
Is there a feared consequence?	Often no, or it is about overwhelm and access.	Often yes: harm, death, contamination, punishment, danger.

Question to ask	More likely autistic need/routine	More likely OCD compulsion
What is the impact?	May support functioning or reduce overwhelm.	Often shrinks life, increases distress and takes more time/energy.

A helpful phrase from the session was: “This started as something I wanted to do, and it turned into something I felt I could not do.” That can be a sign that a sensory support or routine has become tangled with OCD fear.

10. OCD, checking and executive functioning

Poor working memory, ADHD and executive functioning differences can contribute to checking and completion compulsions. The person may genuinely struggle to remember whether they locked a door, turned off an appliance, sent a message, packed an item or finished a task. That lived experience of forgetting can make the brain feel less able to trust itself.

A possible loop is:

- Working memory uncertainty: “I cannot remember if I did it.”
- Anxiety or threat: “What if something bad happens because I forgot?”
- Checking: “I need to check again.”
- Short-term relief: “Now I feel safer.”
- Long-term loop: the brain learns that checking is the only way to feel safe.

Neurodivergent-friendly supports

- Use a single visual checklist rather than repeated mental checks.
- Take one photo as evidence, then agree not to re-check the physical item repeatedly.
- Say the action out loud once: “The door is locked.”
- Use a “one trusted check” rule with a supporter if needed.
- Reduce uncertainty by externalising memory, while avoiding endless reassurance loops.

11. OCD, binge eating and bulimia cycles

Binge eating and bulimia can involve medical risk, especially where purging, restriction, fainting, dehydration, or electrolyte imbalance may be present; this section should be treated carefully. NICE guidance recommends structured support for eating disorders, including guided self-help and CBT-based approaches, depending on the person’s needs.

OCD may maintain binge eating or bulimia cycles through:

- Fear of being “contaminated” by certain foods or past experiences.
- Moral rules around food, such as “I have eaten wrong, so I must undo it”.
- All-or-nothing thinking: “I have ruined it now, so there is no point.”
- Body checking, weighing or reassurance seeking.
- Purging, restricting or compensating as a compulsion to neutralise fear, shame or guilt.
- Interoception differences, such as difficulty reading hunger, fullness, nausea or anxiety sensations.

Three neurodivergent-friendly starting strategies

1. Name the loop without shame: “What was the trigger, what did my body feel, what did OCD tell me, and what did I do to get relief?” This turns the focus from blame to pattern recognition.
2. Reduce rigidity gently: keep safe foods, avoid moral language such as “good” or “bad” foods, use predictable meal scaffolding, and make tiny changes rather than sudden food rules.
3. Create a pause-and-support plan for urges: drink something, move to a different space, use a sensory grounding object, message a safe person, set a five-minute timer, and ask, “What is my brain trying to protect me from right now?”

Anyone experiencing binge eating, bulimia, purging, or significant restriction deserves specialist support. A GP, eating disorder service, Beat Eating Disorders, or urgent support should be contacted if there is a physical risk or crisis.

12. Magical thinking, counting and repeating compulsions

The example given was someone needing to close a cupboard door a set number of times and fearing that a relative may die if it is not done correctly. This can involve magical thinking OCD, harm-related OCD, counting/repeating compulsions and “Just Right” OCD.

The obsession is the fear: “If I do not do this correctly, something terrible will happen.” The compulsion is the repeated closing, counting, restarting or checking. The relief is short-term, but the OCD loop usually becomes stronger over time.

Self-help ideas, approached gently

- Name it: “This is an OCD fear. I am scared, but the ritual is not what keeps people safe.”
- Use a purposeful pause before repeating the ritual.
- Avoid jumping from nine repetitions to zero; that may be too big a step.
- Start with a tiny delay, a tiny reduction, or a planned support phrase.
- Ask for support from one trusted person, especially if the person is at risk of getting into trouble in their living environment.

Suggested wording for someone scared to tell staff or carers: “I am having an OCD fear that something bad will happen. I am not doing this to be difficult. I need support, privacy and understanding, not punishment.”

13. How many different types of OCD are there?

There is not one fixed number of OCD types. OCD is usually one diagnosis, but people often talk about “themes” or “presentations”. These can change over time and can overlap.

Common OCD themes include:

- Contamination OCD.
- Emotional contamination OCD.
- Checking OCD.
- Harm OCD.
- Relationship OCD.
- Religious or moral OCD, sometimes called scrupulosity.

- Sexual intrusive thought OCD.
- Symmetry, ordering and "Just Right" OCD.
- Counting and repeating compulsions.
- Health-related OCD.
- Existential OCD.
- Somatic or sensorimotor OCD.
- Pure O, where compulsions may be mostly internal or mental.
- Responsibility OCD.
- Perfectionism-related OCD.

The core loop is usually: intrusive thought, image, urge, sensation or feeling → distress/uncertainty → compulsion, avoidance or reassurance → temporary relief → stronger OCD loop.

14. What therapies may help?

The most commonly recommended evidence-based treatment for OCD is CBT, including ERP. NICE recommends different levels of support depending on how much the OCD affects functioning, and also recognises that some people may need medication such as SSRIs, especially when distress is severe or when psychological treatment is not accessible or has not been enough.

For neurodivergent people, the type of therapy matters, but so does the therapist's understanding of neurodivergence. A helpful therapy can become inaccessible if it ignores sensory distress, PDA, trauma, burnout, communication differences or executive functioning.

Approaches that may help, depending on the person

- CBT with ERP, adapted for autism, ADHD, PDA, trauma and sensory needs.
- Compassion-focused approaches, especially where shame is strong.
- ACT (Acceptance and Commitment Therapy), which can support a different relationship with intrusive thoughts.
- Trauma therapy where OCD is linked to PTSD, medical trauma, bullying or emotional contamination.
- Family work or parent/carer support, because OCD often affects the whole household.
- Medication discussions with a GP or psychiatrist, especially where distress is severe or the person cannot engage with therapy.
- Specialist eating disorder support where bingeing, purging, restriction or body checking are present.

Please note: Clinical guidance often names CBT with ERP as a recommended treatment for OCD. However, many Autistic, ADHD and PDA people find standard CBT/ERP inaccessible or even harmful when it is delivered without neurodivergent-affirming adaptations. The issue is not only "what therapy model is used", but whether the therapist understands neurodivergence, sensory needs, trauma, autonomy, masking, burnout and the person's lived experience. Helpful support should reduce shame, increase safety and work with the person's nervous system, not force them to white-knuckle through distress.
IFS Therapy was also mentioned by a member: Some people may also find IFS/parts-based approaches helpful because they encourage compassion towards protective parts of the self. This can fit well with seeing OCD as an "overprotective friend".

Questions to ask a therapist or service

- How do you adapt OCD treatment for Autistic, ADHD or PDA clients?
- How do you work with sensory needs and trauma?
- Can sessions be online, shorter, camera-off or supported by a parent/carer?
- Can you work with the person's interests and autonomy?
- How do you avoid shame-based language or forced exposure?

15. Books and resources

The following resources were discussed in the session or added afterwards for further learning. Some mainstream OCD resources use language that may need to be softened or adapted through a neurodivergent-affirming lens.

Mentioned in the session

- I Didn't See You There - a poetic memoir about mental health crisis, diagnosis and embracing neurodivergence. Amazon - I Didn't See You There
- You can contact Anna Sackley directly through Facebook Messenger service, Founder of The Neurospicy OCD Support Community, Facebook link: Neuro Spicy OCD support community
- Anna also has Supporting 1-to-1 Neurospicy OCD Mentoring Services
- The Self-Compassion Workbook for OCD by Kimberley Quinlan.
- OCD-UK: OCD and Neurodivergence resources, lived experience and signposting.

Further learning

- Break Free from OCD by Fiona Challacombe, Victoria Bream Oldfield, Paul Salkovskis and Roz Shafran.
- Overcoming Obsessive Compulsive Disorder by David Veale and Rob Willson.
- Overcoming Unwanted Intrusive Thoughts by Sally Winston and Martin Seif.
- The OCD Workbook by Bruce Hyman and Cherry Pedrick.
- Freedom from Obsessive Compulsive Disorder by Jonathan Grayson.
- No Bad Parts by Richard Schwartz - not OCD-specific, but relevant to compassionate "parts" language and Internal Family Systems.
- Beat Eating Disorders - support for binge eating, bulimia, restriction, ARFID and eating disorder concerns.

17. Gentle reflection prompts

- Where might I be white knuckling through something instead of needing support?
- What does my OCD, anxiety or protective pattern seem to be trying to keep me safe from?
- Is there a routine or support that helps me regulate, or has it become something I feel terrified of not doing?
- What would one tiny, compassionate pause look like?
- What scaffolding do I need before I can safely try a change?
- Who feels safe enough to support me without shame or pressure?

18. References and signposting

NICE: Obsessive-compulsive disorder and body dysmorphic disorder: treatment, Clinical guideline CG31. NICE states that recommendations should be considered alongside individual needs, preferences and circumstances, and its OCD guidance was last reviewed in July 2024.

NICE CG31 OCD/BDD guidance

NICE recommends CBT, including ERP, for OCD, with intensity depending on functional impairment, and notes that home-based or telephone CBT may be considered for some adults who are housebound or unable to attend a clinic.

NICE OCD/BDD recommendations

OCD-UK has a dedicated OCD and Neurodivergence resource page with presentations, resources, lived experience and signposting.

OCD-UK: OCD and Neurodivergence

International OCD Foundation: Emotional contamination information, including magical thinking and superstitious behaviours.

IOCDF: Emotional Contamination

NICE Eating Disorders guideline NG69: guidance on eating disorder recognition and treatment, including binge-eating disorder and bulimia nervosa.

NICE NG69 Eating disorders guidance

Beat Eating Disorders: UK eating disorder information and support.

Beat Eating Disorders

A heartfelt thank you to Anna for joining The Neurokin Community and for sharing her lived experience, knowledge, and compassionate insight on OCD and Neurodivergence.

We are also so grateful to every Neurokin member who attended, asked questions, listened, reflected and shared their own experiences. These conversations are so important. Without spaces where lived experience is heard and valued, many Autistic and Neurodivergent people, families and carers are left feeling isolated, misunderstood or blamed. Community matters because it reminds us that we are not alone. It creates space for connection, validation, learning and hope.

Thank you, Anna, and thank you to our Neurokin Community for showing the power of shared lived experience.

Want to find out more about The Neurokin Community?

The Neurokin Community is a neuro-affirming space for Autistic and Neurodivergent people to connect, learn, share lived experience and feel less isolated.

To find out more about joining our community, please visit: https://www.neurodiverseadventures.com