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**OCD**

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**Obsessive Compulsive Disorder** is

defined as an anxiety disorder characterized by recurrent, unwanted thoughts known as obsessions or rituals known as compulsions, which feel uncontrollable to the sufferer. These recurrent and obsessional thoughts or compulsive acts can take on various guises and can sometimes be hard to spot as frequently they are hidden from public display.

For many, rituals such as hand washing, counting, checking, or cleaning are often performed on an obsessive basis. These actions carry the hope of preventing obsessive thoughts or making them go away. Performing these rituals, however, provides only temporary relief, and not performing them markedly increases anxiety. Left untreated, obsessions and the need to perform rituals can take over a person's life. Obsessive-compulsive disorder is often a chronic, relapsing illness.

Some of the more common forms of OCD include the following.

**Fears of Contamination.**

The sufferer has repetitive and intrusive thoughts that they have been contaminated by germs or toxins. These toxins are usually those present in general household products and commonly accessible. The concern is that once they are contaminated they may as a consequence contaminate others and pass it on to people they come in contact with. Obsessions also consist of unwanted intrusive and repetitive thoughts and mental images, which consequently lead to compulsions usually to mitigate the effect of the obsessions. For example, an obsession may present the intrusive thought: “my hands are contaminated by germs”, the compulsion then consists of the action of hand washing to remove the perceived contamination which cancels out the anxiety caused

by the obsession. The obsessive washing is carried out to attempt to cancel out contamination obsessions. It's most common manifestation is repetitive hand washing although washing rituals are also carried out on the entire body, clothing, crockery, worktops and such like. However virtually anything that can be cleaned may be subjected to compulsive washing rituals. And the list is potentially endless. Washing compulsions are carried out whenever the sufferer's mind is beset by obsessive thoughts that their personal environment has been contaminated. Sometimes when the condition is severe items that cannot be washed are totally discarded. Often washing is supplemented by the use of disinfectant and bleach based cleaners. However major conflict may arise adding an extra dimension of torment if the sufferer has obsessions concerning contamination by toxins when the impulse arises to use cleaners such as those already mentioned to decontaminate germs. Compulsions increasingly become more frequent and the more severe it becomes the more and more difficult to quell the anxiety induced by the obsessions that present ever-increasing scenarios of doubt concerning the effectiveness of decontaminating rituals. Needless to say this causes unending mental torment for the sufferer and while this is going on inside their head they are still trying to get appear "normal" to those around them. The resultant internal conflict can have serious consequences. The circle of thought and actions becomes another area in the person's life that needs total and destructive attention.

#### **Fears of harming others.**

Fears of harming others are a close ally of contamination fears although they can sometimes be a full manifestation on their own. Along with the contamination aspect, sufferers have fears of having inadvertently caused an accident such as running someone over even though all evidence points to the contrary. Yet they will return to the believed scene of the accident and scrupulously examine it until they are satisfied

that things are ok. Even then there may be some doubt which lurks in the back of their minds with the possibility of re-emergence. Or the sufferer may have fears that they will accidentally hurt someone with a kitchen tool having experienced an intrusive thought or even visual image of committing such an act. This type of action is totally at odds with the nature of the person and even though none of these feared impulses are ever carried out yet the sufferer continues to be tormented by them.

### **Fear of breaking religious rules.**

Such obsessional thoughts usually include excessive moral concerns. Religious obsessions frequently include blasphemous thoughts and excessive religious behaviours including a heightened sense of responsibility. Constant repetitive praying, church visits and begging for forgiveness plays a role for many suffering from this obsession. It is common amongst many sufferers of OCD to be plagued with doubts concerning moral behaviours and many develop a hypersensitivity about what is right and wrong. Many try to enforce their beliefs onto other people through emotional blackmail and constant nagging, usually coming from their own base of fear. Obsessive preoccupation with confessing imaginary sins may be part of this also. Such “sins” may be very trifling in nature according to the perspective of most non-sufferers and non-believers but they are passionately believed to be evil by the sufferer.

### **Intrusive evidentially unfound thoughts.**

Such unwanted thoughts or visual images may concern obsessions that include fears of becoming pregnant or having made someone pregnant. Sufferers put themselves through painful periods of reflection and torturous thoughts attempting to clarify the events leading to such conclusions. Most often suffers actions could not possibility

lead to pregnancy but the problem is in the sufferer believing they could and indeed have done so.

### Superstitious obsessions.

Thoughts may concern superstitious beliefs that certain numbers, names or colours are unlucky. Obsessions of this nature may eventually be reduced to specific items or places, such as a particular item of clothing or colour being unlucky. Many such OCD sufferers invent their own unique set of superstitious behaviours and compulsions involving just about anything along with exaggerated concerns and behaviours involving more commonly known superstitious practices. Again many of these practices are associated with religious beliefs. Praying at certain statues at certain times and in a certain manner could be seen as such a practice. The sufferer believes that if the praying is not done in a specific ritual then its effects are void and they go to great pains, often repeating the process many, many times, to ensure it's right.

### Checking compulsions.

Checking compulsions are also carried out to quell the anxiety that arises from obsessive thoughts which cause the sufferer to doubt if they have completed a vital task, for example unplugged the iron or locked to doors and windows. They may be so anxious as to return time and time again doubting that the task has been completed even though it was carried out only moments earlier. This is also common with regard to car doors being locked. Consequently in severe cases a sufferer may return back to the car after walking some considerable distance to check that it is locked. When travelling the sufferer may return home to check if the gas is off and the door is locked irrespective of the journey involved. A frequent compulsion amongst sufferers consists of checking letters and any written documents for mistakes or to check that nothing offensive has been written.

A common compulsion for motorists with OCD is to keep checking that they have not caused an accident; the sufferer may return again and again to see if there are any injured persons in the road and may even check with the police or hospitals for evidence that they have not caused an accident. As with contamination compulsions, checking compulsions grow in frequency and severity as doubt increases requiring more and more time consuming and exhausting checking rituals to subdue the mounting anxiety. It becomes a never-ending circle of doubt and checking totalling depleting the sufferer of normal energy levels and peace of mind.

### **Touching.**

This compulsion presents as an overwhelming impulse to touch certain objects over and over again. In Cork this is commonly known as “tipping” where people witness others constantly “tipping” and object such as a table while carrying on a conversation. Most sufferers are unaware that this happening and will be very defensive of it when challenged.

### **Counting.**

This presents as a compulsive urge to count any collection of items such as books on a shelf, lampposts, and steps along the road and so on.

### **Obsessions with symmetry.**

Obsessions of this type concern preoccupations with having things just right such as the need to have pictures hanging straight. Taking extreme concern with orderliness and alignment. We can all refer to Jack Nickelson’s role in “As good as it gets” and his obsession with avoiding walking on paving stone divides.

### **Hoarding.**

This is a compulsive need to have and to keep useless objects most common of which are old newspapers. However as time progresses the sufferer becomes unable to throw

anything away keeping letters, receipts, bills, cloths, furniture occasionally even food or unused medication for years and years. Eventually the home of a sufferer of a hoarding compulsion becomes cluttered, chaotic and a health threat as eventually nothing is discarded.

### **Other OCD characteristics.**

In addition sufferers of OCD will compulsively be involved in rumination. Such ruminations can be upon profound subjects such as philosophy, religion and the meaning of life. These can also take the form of very trivial matters such as how long should I brush my teeth? Was the water I made the tea with really boiled? The list could be endless and again very individual. Many hours of such can take place or ruminations can occur in the background whilst the sufferer is involved in other activities or even whilst involved in other obsessive-compulsive behaviours.

Doubt is another characteristic of the OCD sufferer, the French once called OCD la folie de doute the doubting disease. Doubt is the emotion that feeds most obsessive and compulsive behaviours particularly checking and washing compulsions.

Guilt is another characteristic of most OCD sufferers along with feelings of over responsibility. Many experts agree that sensitivity towards strict religious practices plays a part in this. Both doubt and guilt seem to provide motivation self sabotage and self distrust even though both reactions may be totally unreasonable.

### **A guide to the treatments OCD.**

There are three methods of treatment for sufferers of OCD. The first is the use of Drug Therapy. Mainly SRI's (Serotonin reuptake inhibitors) and SSRI's (SELECTIVE Serotonin reuptake inhibitors) are used to increase the levels of Serotonin - a chemical messenger in the Brain. I am not qualified to speak about this area and suggest a chat

with one's doctor should a person feel that medical intervention may help. Frequently the illness has developed very far before a person seeks help and medication is strongly suggested to help the sufferer refocus on a path of tackling this problem. The other frequently suggested method of treatment is, Cognitive Behavioural Therapy. This can consist of exposing the patient to her or his obsessional fear (for example, making a germ-obsessed person touch a dirty floor) and then delays their compulsive response (immediately washing their hands). The aim is to ease distress. Over a period of time the person learns to become less and less afraid and anxious by their fears - they learn to handle the anxiety.

It is based on the premise that whatever the person does regularly, good or bad behaviour, the brain picks up and does automatically. So, if that behaviour is good behaviour the brain's chemistry will start to change. Dr. Jeffrey Schwartz has written widely on this matter and makes the following suggestions of four basic steps which allow a sufferer to do behaviour and response prevention on their own. These are as follows:

### **Step 1. Relabel**

Learn to recognize obsessive thoughts and compulsive urges - and do so assertively. Start calling them "obsessions" and "compulsions." Realize they are symptoms of your illness and not REAL problems. For example, if your hands feel dirty or contaminated, train yourself to say "I don't really think my hands are dirty; I'm having an obsession that they are. I don't really need to wash my hands; I'm having a compulsion to do so." After a while the brain learns to realize that these are just false alarms - false messages caused by the imbalance. You can't make the thoughts and urges go away because they are caused by this biological imbalance, but you can control and change your behaviour response.

## **Step 2. Reattribute**

"It's not me, it's my OCD." Learn to reattribute the cause of these thoughts and urges to their real cause. This will increase your willpower and enable you to fight off the urge to wash or check.

## **Step 3. Refocus**

this is where the real hard work is done. Learn to refocus your mind on something else. Choose something pleasant like a hobby - listen to music, play sport, go for a walk, whatever it takes to make your mind think of something other than the obsessions and compulsions that it WANTS to think about. Say to yourself, "I'm experiencing a symptom of OCD. I must refocus and do behaviour." This is not easy, and a person should adopt a FIFTEEN MINUTE RULE. They should delay their response by letting some time elapse, preferably fifteen minutes, but a shorter waiting time at first.

During this time they should re-check through all the steps. Be aware that the intrusive thoughts and urges are a result of OCD and that this is an illness, a biochemical imbalance in the brain. Try to focus on something else. After the fifteen minutes, reassess the urges. Take note of any change in their intensity and this will give the person courage to wait longer next time. The longer it's left the greater the decrease in intensity.

## **Step 4. Revalue**

Begin to realize that these thoughts and urges are a result of OCD, and learn to place less importance on them and less importance on the OCD. Learn to take back control, take charge. In the short term, feelings can't be changed but behaviour can be, and in time the feelings change too. Dr Schwartz, in his conclusion, says, "We who have OCD must learn to train our minds not to take intruding feelings at face value. We

must learn that these feelings mislead us. In a gradual but tempered way, we must change our responses to the feelings and resist them."

*While respecting and indeed embracing the above mentioned methods it is my professional opinion that OCD is far more than what is referred to as an anxiety disorder needing behavioural change. The term "anxiety disorder" is all encompassing and frequently there are common threads of life experience running through the life histories of those affected. Yes OCD most certainly causes anxiety, and anxiety is unmistakably one of its main symptoms but sufferers frequently have a history of life experiences that contributed greatly to that basic anxiety. Therefore a third lesser promoted vital method of helping is sometimes overlooked.*

*OCD also causes depression, social isolation, extreme fear, feelings of hopeless, a sense of uselessness, profound regret for all the wasted years that it consumes. It eventually can lead to a plethora of psychosomatic disorders and can be a very incapacitating illness.*

*It appears to be a psychological illness with a biological/physical component rather than purely psychological. Research suggests that chemical activity in the brain involving the neurotransmitter serotonin may be responsible for OCD. I am not an expert in this area excepting to say that being less anxious and having a positive self image and outlook contribute to the release of more serotonin.*

*My clinical experience suggests that the manifestation it takes is mainly psychological and is as unique as is each individual and is dependant upon family of origin upbringing, education and life experience. Certainly similarities amongst individuals affected by OCD exist and these can be put into categories, such as contamination OCD, religious/ scrupulosity OCD, checking OCD and so on. But*

*each presentation of OCD is unique to the individual person, no two people seem to present with exactly the same obsessive behaviours and compulsions. However some people who develop OCD are believed to be born with a genetic predisposition to develop such a condition and it is only the form that it takes that is affected by the circumstance of upbringing and so on. A high state of awareness as a child, as well as early manifestations of accountability and responsibility, appears to be a common link between sufferers.*

*I am convinced that prior to any treatment being undertaken there is need for a qualified and experienced therapist to undertake a “fact-find” type interview with a sufferer. The therapists need to explore on four specific areas of investigation and encourage the sufferer to talk about any situations brought to mind by the areas. They are issues in the sufferer’s life that concerned with what I call the L.E.S.S. (lies, embarrassment, secrets and shame) principle. Where one or more of these issues are present and in manner deeply affecting the person with a tendency towards OCD, the obsession and compulsions are usually far more severe. By therapeutically dealing with historic issues involving L.E.S.S. the sufferer removes some of the basic motivators for the actions and makes it easier for medication and treatments like CBT to be more successful.*

*One other area needing attention concerns feelings of self-worth and self-esteem. I have found affirmations to be very helpful in this regard. One of the motivating factors in encouraging sufferers to take these actions and investigations would be to discuss with them in a non-judgemental manner their inability to trust themselves and their amazing ability to focus negative energy to sabotage their contentment. If you are concerned about OCD in yourself or someone close to you it would be important to seek help. Whichever path you decide to take for treatment I strongly*

*suggest that you firstly discuss the matter with your GP and should you choose to then go on for psychological help don't be afraid to clarify the therapist's familiarity with the aforementioned suggestions.*

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