OBSESSIVE-COMPULSIVE ISSUES

Gentle Trauma Release Method ©

OBSESSIVE-COMPULSIVE ISSUES

DEFINING OBSESSIVE COMPULSIVENESS

- Many people are familiar with Obsessive-Compulsive Disorder: if not personally, then because of the many fictional characters portrayed in literature or TV shows (Mr. Monk, Monica Geller).

- OCD (Obsessive-Compulsive Disorder) is actually part of a bigger category, officially called **Obsessive-Compulsive and Related disorders**. This category includes challenges such as:

    - OCD itself
    - Body Dysmorphia
    - The Hoarding Disorder
    - Trichotillomania (Compulsive Hair Pulling)
    - Excoriation (Skin picking disorder)

- Typically, if you are not a psychiatrist or a therapist you probably wouldn't come across someone who has a full-blown case of OCD. Your clients may have a milder or slightly different version of a disorder that doesn't meet the official diagnostic criteria. However, that doesn't mean that the person isn't suffering as a result of it or that they don't need help.

- Your clients may not need an emergency intervention or hospitalization because of their issues and they can still function in life, but their life is very far from being optimal and they do suffer as a result of these issues. Life is way harder than it has to be for them.

OBSESSIVE-COMPULSIVE ISSUES

OBSESSIVE-COMPULSIVE DISORDER

- OCD has two main features: obsessions and compulsions. To be officially diagnosed with OCD you need to have at least one of them (or both).

- **Obsessions** are thoughts, images, or urges that are:

    - Persistent
    - Intrusive
    - Recurrent
    - Causing intense anxiety and distress

- There are different kinds of obsessions and they usually revolve around a certain theme. For example:

    - Harm
    - Symmetry
    - Contamination
    - Religion
    - Sexuality

- Compulsions are very specific kinds of behaviour that are performed in order to dissolve the intense anxiety, discomfort, and fear caused by obsessions.

- There are different kinds of compulsions, but the most common are:

    - Cleaning
    - Repeating
    - Checking
    - Ordering and arranging
    - Counting

OBSESSIVE-COMPULSIVE DISORDER

- People who suffer from OCD don't really want to perform these acts repeatedly, they don't necessarily make sense to them either and can often recognize how pointless these compulsive behaviours such as checking and re-checking are. But they feel like they have no control over these acts.

- Compulsions have the form of a ritual with very rigid rules. The compulsive act has to happen in a very specific way and exactly that way every time. The ritual (i.e the compulsive behaviour) can happen outwardly (e.g. checking and re-checking if the locks are locked) or inwardly (e.g. where a person mentally repeats certain words over and over in their mind).

- Most people engage in behaviours that don't really make sense to one extent or another and that might appear a bit OCD-like (e.g. the pillows have to be arranged in a certain way when we go to sleep; the food has to be arranged in a specific pattern before we start eating).

- OCD-like traits become a problem when the thoughts and images have become intrusive and recurrent, and most importantly, causing high levels of anxiety and emotional distress. Then, the compulsive behaviours performed to counteract those obsessions have to significantly interfere with one's life in that they are very time and/or energy-consuming to the point that one finds it harder to function in the different areas of life.

GTR CASE STUDY: ANETTE'S LOVE OBSESSION

- Annette has been married for many years, but her mind kept flooding her with thoughts of her ex-boyfriend from a long time ago. In fact, even though they broke up decades ago and haven't been in contact since, she would still talk about him in the present tense -as though he was still part of her everyday life.

- Anette would think about her ex-boyfriend daily. In fact, whenever she got distressed, she would repeat his name to herself over and over again to calm herself down (compulsion).

- Anette's compulsive behaviors escalated over time. She would "stalk" her ex-boyfriend online, googling his name and using social media to get more information on him. She would ask their mutual friends about him as well, in order to learn more. This was especially to find out if he still spoke about her and thought about her. This behavior went on daily.

- This case study is a great example of how your client can suffer from a "milder" version of a certain mental health challenge – one which wouldn't necessarily lead to an official diagnosis and yet, their life can be far from ideal because of that challenge. Anette recognized this stalking to be inappropriate and out of line but she had no way out. She didn't know how to make her compulsive behaviors stop.

- The GTR Practitioner who worked with Annette was able to get her to a place where one day she realized that it's been weeks since she has thought of her ex. Today, Anette no longer checks online to find news about him, she doesn't recite his name to herself like a little prayer and she had some huge realizations about the truth of this past relationship – realizations that made it possible for her to move on. And thus, a few GTR sessions eliminated an obsession that lasted for decades.

OBSESSIVE-COMPULSIVE ISSUES

OCD-RELATED ISSUES AND TRAUMA

- Research tells us that OCD often occurs simultaneously with PTSD.
- Recurrent, intrusive thoughts causing extreme distress and anxiety are a feature that both PTSD and OCD have in common. They are one of the main diagnostical criteria in both cases.
- Stress and trauma can potentially trigger or exacerbate inborn OCD predispositions. For example, if someone was born with an OCD predisposition, a traumatic event could create the right environment for their OCD to start expressing itself or for worsening of their already existing OCD.
- There seems to be **trauma-related OCD** where a person develops OCD after experiencing a traumatic event or a series of traumatic events.
- This means that if we manage to identify those events, clear and collapse them, the OCD-like symptoms will go away.
- For example, Anette's GTR© Practitioner helped Anette collapse some core traumatic memories from her past...none of which had to do with the actual relationship with her ex-boyfriend. However, because Anette's trauma was released, Annette's symptoms went away. In her case, the OCD-like behaviors. She no longer looks for her ex online be it through googling or social media, she no longer asks her friends about him, she doesn't recite his name to herself when she is distressed. I fact, she barely thinks of him. And this is because the root cause of her issues (i.e the traumatic events from Anette's past) was taken care of: neutralized and collapsed through GTR.

MAINSTREAM TREATMENT

- The mainstream status quo of OCD treatment consists of:
    - **Medication (mostly antidepressants)**
    - **Exposure and Response Prevention Therapy**

- Exposure and Response Prevention Therapy is based on exposing the person suffering from OCD to the source of their anxiety. For example, if someone has contamination-based OCD, then this would be exposing them to germs or dirt in a guided visualization and eventually in real life. For example, by having them touch a toilet seat in a public bathroom or have them sit on a dirty floor of a public bathroom.

- This process is meant to stop them from engaging in their usual compulsive behavior. For instance, they would be asked not to wash their hands for several hours after touching that toilet seat, The idea would be to show them that if they allow for enough time (usually several hours), their anxiety created by their obsessive thoughts will pass on its own without them having to resolve to the compulsive behavior (e.g. the lengthy, ritualized hand-washing).

- There can be additional "homework". This could be driving the patient with, say contamination OCD, to a spot where there is a dead dog lying on the road. The therapist will then ask the patient to approach and smell the corpse of the dead animal or poke it with a small stick. The “homework” then becomes to put that stick into the patient’s pocket and have them touch it frequently throughout the days to come.

- Some patients refuse this treatment or drop out very early. Those who stay see some reduction in symptoms. But even with Exposure and Response Prevention Therapy, OCD doesn’t go away completely and there is still some degree of obsessions and compulsions left.

BODY DYSMORPHIA

- Body dysmorphia is another challenge that belongs under the umbrella of Obsessive-Compulsive issues. We've seen some promising results here with the GTR Method© as well.

- Body dysmorphia is characterized by obsessions and compulsions just like pure OCD.

- In Body dysmorphia, obsessions take the form of thoughts about body parts that are perceived as:

    - Ugly
    - Disproportionate
    - Disfigured
    - Flawed
    - Defected

- It's important to note that this flaw is either completely imagined or extremely blown out of proportion. Body dysmorphia is characterized by distorted perceptions of one's own body and appearance and by a constant, persistent preoccupation with these perceived body flaws. This preoccupation goes above and beyond the common appearance concerns of people who don't suffer from body dysmorphia. This is an intense preoccupation that leads to extreme emotional distress and pain.

- Compulsive behaviors in Body Dysmorphia tend to take the form of:

    - Compulsive mirror-checking
    - Compulsive grooming and camouflaging
    - Compulsive reassurance-seeking

BODY DYSMORPHIA

- Mainstream treatment: Currently, Body Dysmorphia is treated with antidepressants, although a higher dosage is required than in pure OCD. Then there is Cognitive Behavioural Therapy (CBT) attempting to change the person's perception of the body defect and prevent them from engaging in compulsive behaviors such as checking and camouflaging. This, however, is once again the Exposure and response prevention approach that we talked about in relation to pure OCD.

- While not optimal, at the moment, medication and Exposure and Response Prevention Therapy are what the mainstream has to offer. In fact, many of those suffering from Body Dysmorphia simply end up having excessive plastic surgery.

- The Gentle Trauma Release Method© hypothesizes that at least some cases of Body Dysmorphia, have trauma as their root cause. That is, a person's Body Dysmorphia (perhaps as an inborn predisposition) was triggered by distressing, traumatic events in a person's life.

- In these instances, collapsing core traumatic events and emotions from a person's past leads to elimination or significant improvement of Body Dysmorphia obsessions and compulsions.

SKIN-CUTTING

- The GTR Method© can be helpful even with very difficult to talk about challenges that mainstream Psychology is only beginning to understand. And such is the case of skin-cutting.

- People who engage in skin-cutting deliberately cause damage to themselves but without the intention of committing suicide.

- Skin-cutting is not a completely rare occurrence which is why it has been recently added to the registry of mental health disorders under a broader umbrella of the **Non-suicidal self-injury** diagnosis. Non-suicidal self-injury includes cutting one's own skin with sharp objects, but it can have other forms such as burning one's skin, scratching, head banging, hitting oneself, etc.

- Non-suicidal self-injury, for now, belongs to a category of disorders that need further study. In other words, non-suicidal self-injury didn't get into one of the existing categories such as anxiety disorders, eating disorders or personality disorders because psychologists don't yet have enough information to be able to tell which category non-suicidal self-injury belongs to.

- Obsessions and compulsions seem to be present in skin-cutting. The obsessive part are the recurrent, intrusive thoughts and urges to cut one's own skin. The compulsion is then acting on those obsessive urges. These compulsions have a ritualistic form where the cutter has a good sense of how the "ritual" has to unfold in order to eventually feel relief. Often, the ritual is complete once blood is visible in the wounds.

- Collapsing core traumatic events through the GTR Method© can lead to elimination or significant reduction in the cutting compulsions as demonstrated through the case study presented in the video class.

FINAL THOUGHTS

- There is still a lot of research needed to understand and efficiently treat OCD and related issues.

- On the bright side, at least some of these issues, seem to be triggered and exacerbated by past traumas in a person's life. This means that de-traumatizing the system and targeting the root cause (trauma) of these issues this way can lead to elimination or significant improvement of the client's OCD-like symptoms. And this wonderful news!

MY NOTES

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