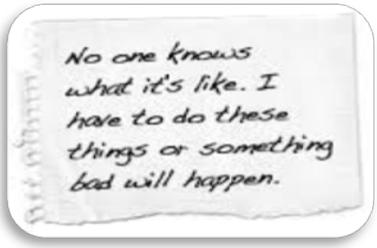
Putting The Brakes On Obsessions and Compulsions



Obsessions are thoughts, ideas, or pictures that keep coming into your mind even though you do not want them to. They may be unpleasant, silly or embarrassing. Compulsions are things that you feel you have to do although you may know that they do not make sense. Sometimes you may try to stop from doing them but this might not be possible. You might feel worried or angry or frustrated until you have finished what you have to do (Taken from the Children's Yale-Brown Obsessive Compulsive Scale by Goodman, Price et al., 1991).

Compulsions are the rituals we often do to make the obsessions go away for awhile – those obsessive thoughts torment us very much, and make us feel very uneasy. When something we do makes the torment and unease stop, this feels really good! In fact, it feels so good that we learn to do that thing more and more to keep the torment and unease away; this is how those things become rituals. Common obsessions are about dirt and germs, that you've forgotten to do something, or that something doesn't look or feel or wasn't done "just right". Some obsessions are thoughts that make us feel ashamed, like thoughts about hurting someone you love. Common compulsions or rituals are cleaning, organizing things a certain way, checking something over and over, counting, or stockpiling unnecessary things.

The problem with rituals is that they might be taking up a lot of our time. They might be a little silly and they might embarrass us or cause problems with friends. Plus, we might not always have time to do our rituals, or people might not understand our rituals. And if we can't do them, or if someone takes them away, that brings all the torment and unease back even stronger than before! We might blow up at someone, or in a situation, because we can't handle all those obsessions again!

All this doesn't mean we are weak, or lack moral fibre. What it DOES mean, though, is that most people have good enough brakes over their thoughts to stop them when they don't want to think those thoughts anymore. We don't. That traps us in the same thoughts over and over so we can't shift to new thoughts as easily as others can.

All this doesn't mean that we can't do anything about it, though! You CAN recover from the problems that Obsessive-Compulsive Disorder (OCD) creates, and you CAN get rid of all that torment and unease. You know what else? You deserve to!

So let's,

- Of critical importance is to educate the person in what obsessions and compulsions are, and how to recognize when they are interfering with his true intentions. Many children and youth, when first diagnosed, are not aware that the impulses and thoughts they deal with are not common experiences for other children. Furthermore, they may have never known what it is like to NOT have these experiences. Hence, developing the insight to recognize the disorder's influence will take time and patience. It is, however, an integral step for learning to deal with the diagnosis. Doing so will help them to "distance" themselves and their thoughts from the anxiety and discomfort created by the obsessions. Once they are able to do that, they are better equipped to withstand things that do not go 'just right' without subsequent outbursts or turmoil.
- A good way to begin this education is to **externalize the obsessions**; **create a name** together for them (Mr. OCD, That Silly Brain Tic), and reframe problem situations as the Mr. OCD getting the person into trouble, rather than the person choosing to get into trouble him/herself. When the person is experiencing a moment of inflexibility, address the disorder rather than him/her. Finally, creating a code-phrase (e.g. "STUCK"! "BRAIN-LOCK!") to use when the person is lost in an obsession may be a way of breaking the hold and cueing everyone that the true enemy in a situation is that obsession, and not each other.
- When in the midst of discussing a "brain-lock", enquire as to what exactly the thought is the person is experiencing which is causing him such angst. Doing so can illuminate new potential avenues for problem solving the situation (e.g. finding a way to satisfy the anxiety in a less obtrusive way). Knowing the anxiety-provoking thought can also allow others to help the person realistically appraise how "dangerous" the thought really is, thus further distancing himself from the anxiety (e.g., "what do you think might happen if you don't _____? What is the worst that could happen? How likely do you really think it is that this would happen?).

Exposure and Response Prevention (ERP) therapy is highly effective with OCD and could be explored as a treatment option. Here's how it works: since the only reason we do the compulsions is because the thoughts bother us so much, we work to make the thoughts less bothersome. Those thoughts might still be there because our brakes are still leaky, but they don't have the same power over us that they used to. This means we don't need to do our compulsions and rituals anymore, because who cares now if those thoughts are in our heads or not! You might even learn to laugh at those silly thoughts trying to make you do things you don't want to do!

People can go to a Psychologist to learn how to do ERP; there are also different books that teach parents about ERP and how to do this with their children. Some of these books are listed in our Brake Shop bibliography.

People are sometimes concerned that spending a whole lot of time facing their obsessions will make their compulsions WORSE instead of better, but this isn't true. Other people get scared that, by losing the fear around their obsessions, this means that they will actually start to do all the

awful things they might be thinking about. That isn't true either.

Medication. An appointment with a physician who specializes in anxiety disorders and who is familiar with psychotropic medications such as Selective Serotonin Reuptake Inhibitors (SSRI's) and tricyclic antidepressants (e.g. Anafranil) can be considered. This might be a psychiatrist, a pediatrician, or a neurologist.

Medication is important if the ERP therapy listed above is not available or appropriate, or if the obsessions and compulsions are SO strong that it is impossible to even START therapy. Otherwise, the ERP therapy works very well on its own, and teaches the person skills to keep the OCD symptoms from coming back again over time. Medication doesn't work as well on its own, and doesn't keep OCD from coming back as well either.

It is difficult to fight every obsession at once; it is important to work on bothersome thoughts one by one. As well, some obsessions if properly channelled and controlled can help you rather than hurt you (for example, thoughts around doing schoolwork really well might help your grades!). Therefore, some strategies below suggest how to 'adapt' to certain obsessions and compulsions or accommodate them into your life in ways that will not create problems.

It is helpful for us and for those around us **to recognize 'triggers' for certain obsessions**, which then lead to the compulsions. Maybe whenever we go to a certain place, or do a particular thing, this makes those thoughts appear. Triggers could be certain toys, time of the day, amount of sleep the night before, amount of stimulation in the room (i.e. number of people or amount of noise), seeing a particular object out of place, or many other things. Some of those 'triggers' might be completely avoidable, so that we limit the times all of those thoughts will be popping up. This is a good plan at times when there just isn't enough time to do the compulsion or to 'shift gears". On days when it can be predicted that it will be a "bad brain-lock" day, the day should be organized to anticipate difficulties – more transition time planned between activities for example.

For activities that you know 'trigger' the person's obsessions, spend some time together **deciding how long you will spend on that activity**. Decide this before starting the activity though, otherwise you'll already be 'triggered' and it will already be hard to think about it clearly! Create clear end-points to the activity and time them to occur at the start of something else equally interesting to you. **Time Timers** may be helpful visual reminders – available for sale at **www.addwarehouse.com**, these timers are set by moving a red disc counter clockwise to the desired time interval. The disc diminishes as time elapses until no red is visible on the timer face.

Establishing many predictable routines will be important in decreasing the person's anxiety, as they can rely upon the increased external structure. Routines will also make transitions between activities go more smoothly, as transitions can be made part OF the routine. It is even possible to plan for the unexpected by developing a routine to rely upon at these times – a routine for when you don't know the routine!

At times when a change in the routine is unavoidable, provide advance cuing (perhaps in a "good news/bad news" format) to allow the individual ample time to break from the present activity and gear up for the new activity.

Using a computer for homework and also for as much schoolwork as possible (e.g. on a laptop, or using an Alphasmart) can be a really good idea for a number of reasons. Many times frustrations develop from obsessing on letters or page layouts that don't look 'perfect' or 'just right'. On a computer every letter is always precisely formed, lined up, or centred how you want it, and page layout can be changed in a snap! Also, these days the memory storage capacity of

computers is enormous; any obsessions around keeping many useless things (called 'hoarding') can be easily accommodated on a computer.

If computer-use is not available or possible, **using a scribe or providing the individual with photocopied notes** is the next best thing. Don't ask for hand-written work to be redone as this will only further exacerbate compulsions around hand-writing.

Sometimes it may seem like it is impossible to reason with the person experiencing obsessions and compulsions. This is because the person is 'stuck' – it doesn't mean that what you are saying isn't sensible and it doesn't mean that the person with OCD wants to disobey you or pull you into a power struggle. They might want to shift away from whatever they are doing or saying just as much as you want them to! The more they try, though, and the more they think about it, the harder it gets to stop.

For this reason, distraction can work really well with people who are obsessing. Using humour is an excellent distracter; it is a way to drive away anxiety associated with the thought so that the person can shift more easily.

Routines should be established for and with the person experiencing obsessions and compulsions, and adhered to as much as is feasible. Doing so provides a constructive "channel" for some of the rigidity. Also, the resulting increased external predictability over his/her life will help to compensate for the loss of control felt over his/her thoughts and behaviours.

Always check to make sure that the person who experiences obsessions and compulsions is very clear in what he is expected to do, and that he knows how to do it. These individuals are more likely than others their age to become "stuck" when feeling uncertain about how to proceed with a chore, a task, or a school assignment. These are also children and youth who may repeatedly ask the same questions over and over to cope with that anxiety.

Finally, here's some handy **"Don'ts" and "Do's"** for family members and friends supporting those with OCD; I've taken some ideas from Dr. Fred Penzel, who helps people with obsessions and compulsions, and expanded on them:

- **DON'T force the person to get help.** You can't care more about treatment than they do, otherwise this simply becomes another area of power struggle.
- **…..but DON'T function for them, either!** If the person is getting his/her needs met anyway, why is it worth it to them to bother getting better? This might be hard for you to do – you might feel that you are being mean, purposely leaving the person with OCD in misery. Doing this has important implications for motivating him/her to want help though. If that person is unhappy enough, and the only way for change to happen is for him/her to participate in treatment, then (s)he will be motivated to work at making things better.
- **DON'T be responsible for the person following his/her treatment.** Otherwise, (s)he won't learn anything from the exercises, or feel any personal accomplishment for accomplishing the homework.
- **DON'T try to 'catch' the person** in a compulsion, **show impatience** with slow progress, **or punish him/her for not getting help.** These things all add stress to the obsessions, which is the exact opposite of what we want to do. It will only make the obsessions and compulsions worse!
- **DON'T participate in the person's symptoms.** If you've already been doing this in the past, it is ok to either phase out your involvement OR go 'cold turkey'. Not 'playing along'

may create a lot of anxiety in the person initially (particularly if you've participated in rituals in the past) and may cause some explosions (particularly if you stop 'cold turkey'), but this short-term frustration is much better than a long-term dependence on you. The more you take part in the compulsions, the more you are helping the person to avoid the anxiety the obsessions create. The more (s)he avoids the anxiety the less able (s)he is to tolerate that anxiety. What this all means is that the obsessions will become stronger and stronger, and that person will need you to engage in his/her rituals more and more often, and more and more quickly. Pretty soon the obsessions and compulsions have taken over everyone and everything!

- **DO** see the person behind the disorder.
- **DO** see the person's progress and acknowledge it, and be positive. If (s)he slips up, acknowledge the slip-up but still reinforce the EFFORT.
- **DO** obtain information about treatments, strategies and success stories from websites, books, media sources, and support groups. Plant these seeds in the person.
- **DO** offer to help with treatment
- **DO** support efforts to be independent (e.g. develop own homework). You will not be around forever, and this person must face their obsessions and compulsions for his/her whole life.
- **DO** concentrate on living your own life!

Finally, parents, be sure you request that any relevant accommodations found on this hand-out are added to a formalized **I**ndividualized **E**ducation **P**lan (IEP). An informal IEP may not be implemented or transitioned, whereas a formal IEP is a legislated process that also includes the **I**dentification **P**lacement and **R**eview **C**ommittee (I.P.R.C.) that **must** be adhered to, under the Education Act, (Education Act, Regulation 181/98). Any child with identified special needs has access to this process.

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