LIFE IN THE SHADOW OF ANXIETY; THE MASK OF OCD: And EMDR.

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My focus today is on the etiology of the trauma-based predisposition to ocd.

I would like to demonstrate how the obsessive-compulsive disorder serves the dissociative adult as a MASK thereby maintaining the hidden status of both the traumatic memories, and the dissociation;

and finally I would like to demonstrate how EMDR can be used to target the OCD as an ego state to uncover the dissociated parts, the anxiety and the original trauma.

I would like to share with you some thoughts and examples from my clinic in the form of these goals, which you will find in your handouts:

1. To examine the inter-relationship/co-morbidity of trauma based OCD and dissociation via the methodological tool of emdr.

2. To illuminate the impact this relationship has on gender role and identification via this relationship,

3. to detail instances and circumstances where this co-existence functions within inter-personal relationships, like families and couples as well as intra-generationally.

The example below, illustrates just how the memory of traumatic events and abuse that leads to dissociation and the emergence of various ego states enables the OCD anxiety-motivated ego state to both evolve and becomes the dominant ego state.

The client reported: " because of the abuse I knew I was filthy, and because I was taught to believe I had been "provocative" when I was (brother, father, uncle, neighbor, or unknown) raped. I remember washing and washing and trying to get clean but never able to feel clean."

I see this as the onset of an ocd behavior providing a mask to hide the dissociation motivated by the anxiety and to hide the negative belief – "I am a dirty, damaged unworthy person".

"rape and abuse within this family structure is the "hidden" secret, and the trauma. Because a raped woman is forever banned and damaged, she must do 'something' "out-standing" to "alter" her status.

Belief systems of a culture often create their own unique idealization of behaviors that have become excellent outlets for obsessive-compulsive behaviors.

One outlet or form of compensation enabling status and value as a woman, in some cultures, is obsessive behaviors whose results are visible to others; such as cleaning and

obsessively doing other "womanly" tasks – cooking, ironing, and worrying etc.

HOW DO STORED TRAUMATIC MEMORIES ASSIST IN THE GENESIS OF OCD?

Stored traumatic memories are those unprocessed memories recorded in the brain following an event that is experienced as traumatic by the individual.

The chart in your handouts demonstrates the process enabling the triggering of acquired trauma based pre-dispositional ocd:

Di Silva and Marks demonstrate through clinical case examples that there is a causal link between severe trauma, dissociation and OCD.

Traumatic event → anxiety + overwhelm → detachment → anxiety → emergence of dissociative states → anxiety → PTSD → need to reduce anxiety→ predisposition to OCD → self soothing ritual→ relief → underlying trigger → anxiety → repetition ritual → anxiety → ocd → looping control of ocd.

It is generally recognized that the link is through the underlying anxiety. There is severe trauma, there is massive anxiety, there is pts, there is dissociation, there is a predisposition and then there is the onset of ocd behavior

designed to reduce the anxiety. The trauma that has become a source of disintegration is a given and cannot be changed while the anxiety can be "only" temporarily alleviated.

The repetitive ritual eventually gains control over the body achieving a life of its own.

Pierre Janet (1859-1947) was the "first" among clinicians and researchers who inquired into the nature of dissociation. He postulated that 'successive existences' (his term for alter personalities) were split off parts of the personality, and were capable of independent life and development (Putnam, 1989, diagnosis and treatment of mpd).

In as early as 1903 Janet considered that an emotional shock could be the underlying cause of OCD. He divided the ocd disorder into two types; constitutional and acquired.

Constitutional OCD mostly evolves without dissociation and without post-traumatic stress/ disorder and manifests in terms relating to environmental order; issues of neatness or extreme arrangements with careful attention to symmetry.

Acquired OCD is often triggered, following pts/d and dissociation.

The obsessions of the trauma survivor are to not know his pain and traumatic memories and these manifest in such

ritualistic acts involving OTHER pain and ranging from self mutilation, obsessive tooth brushing or tampering with the body in ways that will keep the mind "other" occupied.

Since Janet's work, insufficient attention has been paid to traumatically induced ocd.

Experiencing trauma triggers a self-protective reaction, a kind of healthy dissociation. When that reaction doesn't work to soothe the anxiety, the memory of the trauma becomes locked in the brain with the anxiety. It is this anxiety that can lead to dissociating the core personality into parts.

A damaged tree secretes resin to cover the afflicted area then sprouts new branches to circumvent the sore spot and continues to grow and remains functional.

The trauma based OCD can be considered as one of these new branches. Eventually it becomes the strongest branch and saps strength from the others.

Anxiety is the primary affect of the main dissociative state. The search to reduce this anxiety finds venue in physical outlets such as drugs, alcohol or, as our focus here, in OCD based rituals.

This OCD state now, seems to dictate to the core/healthy/ primary or integrative self what needs to be done and how to

behave in order to maintain equilibrium in the face of anxiety and keep the system away from peril/s and stay safe.

In a brain that is neurologically predisposed to perseverative behaviors a self-perpetuating behavior pattern develops whose purpose is to reduce anxiety.

These patterns become the controlling ego state for the entire system and function to regulate the basic emotional psychic survival of the core personality/self. These patterns are the essential ingredient for the well being of the self and dominate the life of the person.

The ocd MASK allows no 'thing' to disrupt its task of preventing the resurfacing of traumatic memories.

Preventing the resurgence of the anxiety resulting from the traumatic memories is the prime objective of the pattern no matter how much the normalcy of routine life is interrupted.

The acquired OCD ego-state is both fueled by the anxiety and has anxiety-relief as its goal.

While OCD is considered to be co-morbid with dissociative ego states, I am suggesting here, that the OCD actually becomes the dominant ego-state.

In my practice I have found, time and again, clients who present with OCD such as described above. They are hostage

not only to both the ritual but also to the controlling dominant ego state.

What service does the acquired "OCD ego state" fueled by anxiety provide for the individual? I believe the answer is --- immediate relief of disintegrating anxiety. or Simply stated comfort.

Once the predisposition is triggered and the ocd rituals become embedded, those repetitive ocd behaviors take relentless control of the core self. And become a very controlling ego state in a desperate search for relief.

This ocd ego-state becomes a mask preventing access to the other dissociative ego states as well as to the original trauma and memories.

This OCD state now, seems to dictate to the core/healthy/ primary or integrative self what needs to be done and how to behave in order to maintain equilibrium in the face of anxiety and keep the system away from peril/s and stay safe.

The unprotected traumatized child/ adult experiencing trauma gets locked into a specific behavior pattern of that age and place in time.

By noticing the repetitive self-soothing behaviors of the ocd client it is possible to discover the source age of the onset of both the trauma and ocd.

The healthy self who met the trauma, unconsciously turns on the ocd to insure some BASIC PROTECTION to survive the painful and stuck memories of the traumatic event.

In that way the healthy self seemingly effects some control over what happens.

One has an illusion of control when washing and cleaning and checking. One can never control the original traumatic event.

What we, on the outside see, is the tip of the iceberg, we see, the rituals and the ocd behaviors.

Inside, the core/healthy/ primary or integrative self suffers from confusion, anger, rage, depression, fear, panic, delusions, and, of course, anxiety.

There seems to be a horrific internal battle and power struggle between the internal un-evolved self and the external ego state.

When we consider the severity of the traumatic impact, which results in dissociative states coming into existence, one can only begin to imagine the hell this person is living through.

Because psychic survival is what is at stake and the ocd has taken over it becomes resistant to interventions.

This ocd state needs to learn and know and 'with proof' that the therapeutic offering, is as good and "better" for the core self it protects.
It needs to know it can let go – and the core self it is working so hard to protect will not die.

I think that most of us would agree that when there is ocd; there is a neurological predisposition for its continuous performance.

I am not neurologically/physiologically knowledgeable and therefore, will not make any attempt here to elaborate in any way about the neurological/physiological functioning of the brain in ocd.

What I do believe though, as with other forms of "brain related" disorders, symptoms and/or syndromes is that where there is a predisposing neurological/physiological "reason" for the development of a problem such as ocd, there must also be a triggering environmental factor (the trauma) which stimulates that part of the brain thereby setting that disorder in motion at a level beyond that which is normal functioning.

The unconscious memories of the trauma will continue to motivate the individual to find means to alleviate the

anxiety; and psychological treatment that relies only on symptom reduction does not stabilize the elements that set the individual in search of self- soothing (ocd rituals).

My own clinical observations have shown that "In depth"- roots exploration allows the processing of the masked dissociated parts, once the ocd part feels able to release its hold. This then enables access to the traumatic memories and re-processing becomes possible.

An example of this process is a 30-year-old woman who presented with the following symptoms: she mentioned in her history that she had ocd symptoms (ordering, symmetry, etc) of a milder form from age 6 on. The symptoms increased over time and when she returned from a trip abroad her symptoms became totally out of control.

She told me she spends close to an hour at a time brushing her teeth. She brushes each side of each tooth, in a square formation, counting in multiples of 4 and checking and rechecking to make sure she has done a/the perfect job. She also unfortunately/or fortunately chose to become a dental hygienist, which very significantly increased her anxiety. This excessive tooth brushing extended into an 11 hour a day ritual. She performed this

ritual on her patients for 8 hours a day and on herself for 3 hours. She was additionally tormenting herself with an ethical dilemma about hurting her clients. This was followed by further anxiety at possibly being discovered.

This then served to increase her anxiety level to a fear of having a heart attack from the anxiety at being found out, and finally overwhelming guilt at not being able to take control and stop the behavior.

After she became stabilized on medication, I began using emdr to work on the anxiety elements of the ocd. As the anxiety level and the level of urge were reduced, underlying ego states began to emerge.

As I worked with these different ego states the original traumas came to the fore.

As these traumas emerged and were explored the onset of the ocd behavior was exposed.

Once the client became aware of "where the behavior pattern" came from and this was processed by the client, the anxiety dissipated, with it the urge to perform that particular ocd behavior. By processing the overt ocd ego state and the covert anxiety the same as we would process all other ego states - the ocd behavior is greatly reduced.

The primary ego state is enabled to co-share and or integrate with these other states and has more ability to let go of the rituals.

During the original trauma the core persona had no control. With the onset of the ocd behavior, the person believes they have found some control.

Through the use of the emdr method and using the ocd and addictions levels of urge protocol while focusing on the behavior pattern of excessive tooth brushing, we were led down the path of discovery and recovery.

The Protocol was as follows:

Target image: obsessive tooth brushing by the

'TOOTHLADY'

Nc: I have no control, I must brush

Pc: I can take care of myself, I am clean enough and I am good enough (all three emerged as pc's at the end of the processing.

Level of urge anxiety: 10 of course

Body sensations: mouth, heart palps and full body tension

Post processing: LOU – 1 / VOC 6 and body fully relaxed.

What emerged was the memory of a seriously abusive housemother who took care of her and her peers from the

ages of 2-5. This woman, literally and figuratively, "cleansed" the children in her care. She brushed and scrubbed and sterilized these children relentlessly.

Not only had my client developed this tooth obsession but she also developed excessive "internal" cleansing habits – vaginal douching, enemas, etc., and she can still spend up to three hours at a time cleaning herself internally.

Recalling these memories through the use of emdr enabled the accelerated information reprocessing of these traumatic years and at the same time the process of letting go of this acquired ocd could begin.

She is much more relaxed but is aware there is still much work to be done. And for those concerned - she recently came to the decision that to help herself protect her clientele and reduce some of her anxiety, it would be a good idea to leave the dental arena.

I would now like to share this case, that clearly demonstrates- in my opinion-, the creation of a trauma based pre-dispositional ocd ego state, and the ensuing ocd loop, that function as a MASK for the underlying dissociations stemming from the impact of the original trauma. It is a mask worn to prevent the hidden trauma from being revealed.

This MASK is symbolically unveiled through jb's dream.
Jb is a 45 year old woman, processing through a recent divorce and mother of two sons. She comes from a family of 9 children. She is the 8th and the second of two girls. The struggle to survive left no room for emotions in her large family.

Jb suffers from MDD (major dissociative disorder)- full (DID(dissociative identity disorder)) recognizing all 5 kinds of alter states as diagnosed by the Dell multidimensional inventory of dissociation (MID); and depression. Jb has protected these dissociative states from exposure by hiding them under the mask of acquired ocd. Jb has many more than 5 alter states.

For the past 10 months I have been working with jb "sorting things out". Most of jb's parts are in full cooperation with us both. jb is working very intensively towards making her life move forward positively and responsibly. The "sorter/porter" is jb's primary OCD state. Because jb was medically and exposure response prevention stabilized, we were able to work on these traumas. The ritual targeted was the "bag packing - porter jb". jb carries 'everything' with her.

I worked on this 'controlling ocd pattern' by addressing the ego state in control (with permission from all the others) and using a combination of emdr addiction and ocd protocols.

our first major emdr sessions were with the 'sorter/porter" ocd ego state.

Protocol for the 'sorter/porter':

Target picture: the bags she carries with her everywhere she goes.

NC: I am not ok

PC: I am ok as I am

Emotion: anxiety LOU = 10

Body sensations: full body tension

End of several 90 minutes sessions = LOU = .5 and voc = 6.5 and body tension – comfortable.

What was hidden, and recalled during the processing, under this ocd bag-packing sorter/porter personality was that; while aboard ship, bound for Israel, jb had been made responsible for the documents needed for the emigration for the entire family. This was a very heavy and traumatizing burden for this 12 year old, whose life was totally transformed overnight when she found out she was

jewish and not Christian and moving to israel. JB came to israel in 1967 one day before the 6 day war began. She was already traumatized from the move, and the war trauma was just enough to set her ocd patterns for her.

At the end of our processing – and as per protocol I mentioned that she might want to record her dreams or other recalls that she may have. The last session paved the way for the dream that followed two more sessions and uncovered several of her separate parts/alters/states.

The symbolic language of the dream offers other avenues for recognizing the MASKing the ocd state provides.

This most remarkable dream followed two emdr sessions where; in one, we targeted the traumatic memories around her mother's death; and, in the other, we worked on the shock of discovering that she is jewish.

Within the context of the dream, interpersonal relationships where dissociation + ocd co-exist are seen and the intricate relationships in families are also demonstrated. I present to you jb's dream in tribute to her struggle and as a means to demonstrate how her

dissociation has effected her life, her family and her small community.

You will find jb's full history and the dream and interpretations in your handout.

The crux of the dream is the emergence of her enormous anger and hurt; in the dream someone is calling her names and hurting her. jb allowed this to happen, and said she would still help. several parts of jb emerge in the dream.

A) the angry, fragmented, anxious, child and

b) jb's more extroverted state with whom she identifies, not too strong, not in control, basically okay.

c) the helping helpless state calling for the "responsible" people. The Hierarchy of jb's inner people:

1. The depressed jb in the hole,

2. The observer helper state of jb

3. The responsible caretaker who is helpful and helpless but unable to complete any job alone.

4. The fully responsible jb as represented by her sister and brother.

Time restraints unfortunately prevent us from going through this dream line by line. What I am hoping you will come away with as you read through this dream is the following: through this analysis I hope I have enabled you

1) to see the many ego states represented in the dream

2) to examine the unfolding of the ocd as it takes over

3) to note how the struggle/cooperation of the healthy/hostaged self appears

4) and to recognize this venue of the dream as both symbolic, metaphoric and enabling for the therapist to learn to actualize and understand in specific ways, how it is possible to decode what is happening inside the client and share the internal battle.

JB is currently still sorting out. Through this dream we can also see the importance of the way the "environment "perceives, behaves and responds towards the ocd person, and this is not always favorably.

In the handout – you will also find some short vignettes to consider and perhaps, through these you may be able to further see ways that ocd affects the couple, the family , and how ocd is "transmitted" to the next generation; and perhaps recognize how sometimes one's cultural beliefs can become detrimental to one's life and choice of being and behaving.

In conclusion: Traumatized people are often not able to express themselves not only because the core self is not allowed to surface but because the core/healthy/ primary or integrative self doesn't know that its "being" is right, it doesn't know that it is allowed to BE and is healthy.

I hope I have been able to illustrate

1. that acquired OCD is in fact a separate ego state which evolves following trauma induced anxiety and dissociation. This ocd is a MASK designed to protect the internal core self from the external potentially painful world.
2. there are culturally accepted and applauded ocd symptoms that also help to form gender roles.
3. interpersonal relationships where dissociation + ocd co-exist are mentioned to show the intricate relationships in families.
4. treatment goals for acquired ocd symptomotology should include the search for underlying roots to enable better stabilization in combination with the cognitive, behavioral and medical models. To reach these underlying roots I find that the emdr addiction urge and OCD protocols are most often my first treatment of choice (once there is some physiological stabilization of the symptoms) though I am sure there are other treatment modes.

Stopping the ocd behavior leads the person back into the body, sensations and emotions experienced during the original trauma. Unfortunately, as in the case of addictions, once the behavior pattern becomes embedded there is no easy switch back to the core healthy state. The "anxious ocd behavior pattern" has developed into an independent ego state precisely to prevent the person re-experiencing the traumatic memories. That is the OCD MASK; it dooms the wearer to "a life in the shadow of anxiety under the MASK of OCD.'

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