Obsessive Compulsive Disorder as a Dissociative Defence

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Abstract

In the recent decade, there has been growing recognition of the associations between trauma exposure and the expression of OCD related symptomology. Despite these findings current conceptualizations of OCD remain largely dominated by cbt and biologically based etiologies. With limited theoretical models available to outline the linkages between traumatic exposure and the mechanisms of OCD, this paper proposes that the symptoms of OCD serve as dissociative strategies in the self. Drawing on the circumplex model of emotion and on constructs from emotionally focused therapy models for PTSD, the cognitions and behaviours of OCD are demonstrated to serve a defensive role in the self by inhibiting contact with core feelings states. Newer clinical viewpoints of internal family systems and person centred therapy are explored with emphasis on pluralistic conceptions of self and acceptance based approaches to ocd symptomology.

Keywords: OCD, Dissociation, Trauma, Affect Modulation, Defence Mechanisms

Table of Contents

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Introduction

A new paradigm of Obsessive-Compulsive Disorder is urgently needed. In the lexicon of popular culture OCD serves as a catch all term suggesting anything from a compulsion for order and tidiness to a personality tick requiring one to compulsively double check an email. This belies the significant and often debilitating distress caused by the condition and misrepresents the complex factors at play in its expression.

In more formal settings, clinical interventions and research literature have been dominated by cognitive behavioural therapy and biological based approaches to OCD for decades (Skarphedinsson et al., 2014). Their accompanying interventions styles have been shown to have relatively poor treatment outcomes and high relapse rates (Burchi, Hollander & Pallanti, 2018). However, with emerging research indicating strong linkages between OCD and trauma this paper will suggest an entirely new paradigm: that the cognitions and compulsions of OCD are dissociative defences.

For clarity, the DSM-V currently lists OCD as an anxiety disorder characterized by the presence of obsessions (recurrent thoughts, images or urges) and/or compulsions (repetitive behaviours or mental acts) which cause significant disruption to daily life (American Psychiatric Association, 2013).

In the first chapter, the current conceptualizations of OCD will be reviewed in order to detail the specific limitations of these models and to highlight the urgent need for these paradigms to be revised and re-imagined. This will be followed by an exploration of newer lines of research revealing strong correlations between trauma

and the expression of OCD, leading to the proposition of this paper that OCD is a dissociative defence.

In the second chapter, the concept of defence mechanisms will be defined, and an operational definition of dissociation will be outlined in order to reveal how obsessional thought processes and compulsive behaviours allow a splitting off from affect in the self. Concepts will be drawn from the circumplex model of emotion and emotionally focused therapy to illustrate the dissociative functions of OCD. Furthermore, the conceptual distinctions between helpful and harmful psychological defence functions will be explored in relation to the role of dissociation in OCD.

Finally, the clinical implications of this proposal will be considered, and it will be argued that modalities defining the self as a multiplicity and based in acceptance-oriented approaches are essential to avoid the pathologising stances of cbt and pharmacotherapeutic interventions. Internal family systems and person-centred therapeutic approaches will be applied to the expression of OCD and will be shown as valuable intervention responses to the complexity of this condition.

Chapter One

Existing Paradigms of OCD

In current clinical settings, the criteria for diagnosing and treating OCD sufferers remain strongly influenced by cognitive behavioural therapy and biologically-based models of OCD (Skarphedinsson et al., 2014). Treatment resistance rates for OCD have been shown to be significantly higher than other anxiety disorders and with higher levels of individuals reporting chronic or untreatable symptoms (Burchi et al., 2018; Weissman, Bland, Canino & Greenwald, 1994).

In the cbt conceptualization of obsessive-compulsive disorder, it is theorized that obsessional patterns occur when intrusive cognitions are appraised as being harmful, dangerous or 'wrong' which then lead to negative affective reaction (Cludius, Kulz, Landmann, Moritz & Wittenkind, 2017; Salkovski, 1999). This ensuing negative affective response creates a need for neutralization resulting in compulsive behaviours such as washing or checking and as well as more covert ritualisations (Fava et al., 2014).

Consequently, cbt protocols primarily employ 'correctional' interventions by aiming to restructure dysfunctional processes of appraisal and irrational beliefs related to inflated responsibility. (Murphy & Perera-Delcourt, 2014; Salvoski, 1999).

Alternatively, biologically based theories of OCD suggest that symptoms are driven by a pathology in the neuronal circuitry of the brain (Nakao, Okada & Kanba, 2014; Stein, 2002). Neuroanatomical and neurochemical factors as well as disturbances in the sub-cortical areas of the brain have been proposed as possible determinants of this disorder (Cozolino, 2002; Nakao et al., 2014).

Although a coherent etiological basis for the pathology in these brain systems has not yet been proposed, OCD remains largely conceptualized as a "brain disease" and pharmacotherapeutic intervention remains widely endorsed by leading health authorities (Fava et al., 2014, p.2).

Though both cbt and biologically-based interventions currently maintain prominence as treatment protocols, research outcomes continue to highlight high relapse rates and poor treatments outcomes among both sets of interventions (Burchi et al., 2018).

In studies examining the efficacity of CBT for OCD sufferers, it was observed that only 60% attain 'recovery' and only 25% were asymptomatic after treatment (Key et al., 2017). Furthermore, those who achieved partial recovery have been shown to lose their treatment gains and report significant negative life disturbances from their remaining symptoms (Key, Rowa, Bieling, McCabe & Pawluk, 2017).

Moreover, there is little consensus regarding the determinants of change outcome in OCD symptomology. Research provides inconclusive findings in demonstrating the causal relationship between dysfunctional cognitions and symptom reduction (Schwartz et al., 2017). Multiple studies have found that changes in cognitions and symptoms occur in parallel, while other findings suggest that symptom reduction precedes an actual decrease in appraisals of unwanted thoughts (Schwartz et al., 2017). These findings would appear to undermine the basic axiom of cbt which suggests that errant thought and beliefs patterns drive the symptomology of OCD (Salkovski, 1999).

Similarly, pharmacotherapeutic interventions present relatively high treatment resistance rates where the main class of medication used for treatment of OCD is

SSRIs or selective serotonin re-uptake inhibitors (Burchi et al., 2018). Studies have shown that as many as 40% of individuals treated with SSRIs for OCD did not demonstrate any significant change in symptomology (Burchi et al., 2018; Stahl, 2000). With such high relapse rates and poor treatment outcomes being observed within both forms of intervention, it would appear imperative to revise and re-imagine our current models of OCD.

Trauma and OCD : An emerging Paradigm

Responding to the limitations of CBT and pharmacological approaches, more recent qualitative research has begun to explore the contextual factors at play, particularly the presence of adverse environmental influences in the expression of OCD (Key et al., 2017).

Emerging research has demonstrated that traumatic life events especially adverse childhood experiences, for example: emotional abuse, physical abuse, emotional neglect, physical neglect and inconsistencies in care, are more prevalent among individuals with OCD and among individuals who report high levels of obsessive-compulsive symptoms (Key et al., 2017). Research has also demonstrated evidence of sudden onset of OCD symptoms after single or ‘one-off’ traumatic experience for ex: motor vehicle accidents, sexual assault and experiences in combat situations (Carpenter & Chung, 2011).

Though many of these findings point to a correlative rather than causal relationship between trauma and the presentation of OCD, they highlight the need for further exploration of the linkages between adverse and stressful environmental factors and the expression of OCD related cognitions and behaviours.

In a seminal research study Gershuny, Baer, Radomsky,Wilson & Jenike (2003) identified a series of functional connections between the symptoms of Obsessive-compulsive Disorder and Post Traumatic Stress Disorder through analysing outcomes in a set of patients who met criteria for co-morbid PTSD and OCD.

They observed a bi-directional relationship between the symptoms of PTSD and OCD (Gershuny et al., 2003). The expression of one set of symptoms appeared to attenuate the symptoms of the other. It was noted that when there was a decrease in PTSD symptoms - such as flashbacks or nightmares -this resulted in an increase in OCD associated symptoms and conversely that a decrease in OCD associated symptoms resulted in an increase in PTSD associated symptoms (Gershuny et al., 2003).

Importantly, the findings of this observational study suggest that the obsessional cognitions and compulsive rituals associated with OCD can be employed to alleviate post-traumatic distress. In other words, OCD can serve as a way of coping with the emotional and cognitive distress resulting from a traumatic experience. Following this logic - that OCD serves as a coping function - it is not surprising that OCD treatment resistance was noted to be highest amongst individuals who report having experienced a traumatic life experience (Semiz, Inanc & Bezgin, 2013).

From these empirical findings, it would seem logical to consider the possibility that OCD symptomology may serve as a set of mechanisms to regulate distress and negative affect.

Since Gershuny's findings in 2003, empirical and case studies have continued to suggest strong correlations between a history of trauma and an increase in OCD related symptoms (Fontenelle et al., 2012; Miller & Brock, 2017). However, in the

current body of clinical literature there is no formalized theoretical model to explain how OCD symptoms serve a defensive function or which specific defences might be used. Therefore, responding to the substantial evidence within trauma research demonstrating that dissociative tendencies are frequently used to attenuate the impact of traumatic events, it is necessary to propose a new hypothesis: that OCD serves as a dissociative defence against psychological distress (Bailey & Brand, 2017).

Chapter Two

Defence Mechanisms: An Overview

To consider the function of defence mechanisms - specifically dissociation - in the expression of OCD, it is necessary to review the many conceptualizations of this construct. The term ‘defence mechanism’ arises out of the psychoanalytical tradition wherein the human mind is understood to be a complex web of competing and overlapping energetic processes (Corey, 2010) Freud was the first to use the term though he continually revised and reformulated his perspective on the topic (Clark, 1998).

Freud initially theorized that defence mechanisms, “protect the person from excessive anxiety, whether the source of that anxiety be the perception of a disturbing external event or the presence of a disruptive internal psychological state” (Freud, 1936, p.43). Freud initially proposed seventeen separate mechanisms including conversion, displacement, isolation, projection, repression, and categorized them separately from withdrawal and retreat from reality mechanisms (dissociation) though he did not provide a definitive analysis of any these constructs (Vaillant, 1992).

In his later writings Freud conceded that nearly all mechanisms could be used interchangeably with repression, therefore minimizing the distinctness of each individual mechanism (Janis, 1969). After his death, Anna Freud further clarified that repression was the primary defence and that all other mechanisms should be regarded as simply reinforcing it (Leigh & Reiser, 1980).

More recently the work of Vaillant, refining Freud’s original position, proposed that the perceptions of self, of other, of objects, or ideas and feelings related to

internal and external reality are all altered by defence mechanisms (Vaillant, 2014). Vaillant formulated a categorization system - immature, intermediate/neurotic, and mature - based on the cognitive complexity of the defence and the developmental stage wherein it is first used (Vaillant, 2011).

Vaillant, in contrast to Freud, highlighted the distinctness of each particular defence and introduced a classification system which remains a widely used construct within clinical research (Vaillant, 2014). Empirical findings have strongly endorsed Vaillant's claim that the use of immature defences (for ex: denial, somatization, projection, hypochondria) is linked to psychological impairment while use of mature defences (for ex: humour, sublimation, intellectualization, altruism) is linked to positive psychological and social adjustment (Diehl et al., 2014; Sandstrom & Cramer, 2003).

Defining Disassociation

Dissociation is not a unitary concept in the domain of clinical literature (Giesbrecht, Lynn, Lilienfeld & Merckelbach, 2008). The term first appeared in the work of Pierre Janet in 1889 as the French term, 'désagrégation' meaning a, "deterioration in the unification of experiences at the mental level" (Belli, 2014, p. 328). Freud later defined dissociation by its ability to split affect from ideas (Bowins, 2004).

More recently, Vaillant defined dissociation functionally by its role in altering the internal state of the ego in order to eliminate the discomfort of inner conflict (Vaillant, 2014). Further theorists have defined dissociative defences as forms of, "emotional numbing, absorption, imaginative involvement, depersonalization, de-realization, amnesia, identity fragmentation" (Bowins, 2004, p. 7). A more comprehensive

conceptualization of dissociation will be applied in the following review of its function in the expression of OCD. Dissociation will be understood as, “dispersion in the wholeness of sense of self. This dispersion emerges as the result of the deterioration of the unity of chronological, biographic and perceptive identity” (Belli, 2014, p.328).

This definition was selected as it encompasses the dispersion of thought from affect - splitting according to Freud - as well as the milder forms of dissociative experiences such as absorption which is heavily involved in the cognitions and behaviours of OCD (Belli, 2014; Bowins, 2004).

OCD as a dissociative defence

OCD can be conceptualized as a dissociative defence as it involves a dispersion of self in both the obsessive and compulsive features of this disorder. Focusing first on the cognitive aspects of obsessions, it will be argued that ‘splitting’ occurs in this form of mental patterning. For clarity, obsessions are defined as intrusive urges, thoughts, images which are ego-syntonic meaning they are perceived as, “senseless and alien”, and as disruptions from the normal flow of an individual’s thought process (Wells, 1997, p. 5) Obsessions mainly focus on a very limited number of themes for example : contamination, religiosity, violent images/impulses (Tonne & McDonough, 2012).

Obsessional thinking can be understood as a dispersive and consequently dissociative experience due to its over-reliance on cognitive rather than affective aspects of awareness. This is primarily due to the cognitive absorption required to maintain obsessional thinking where perceptive awareness is repeatedly directed to a singular theme.

This cognitive preoccupation involves a dissociative splitting of thought from affect as it relies on persistent redirection of awareness to the topic of obsession (Bowins, 2004). For clarity, affect can be understood as the various intra-personal or intra-bodily feeling states involved in emotion and mood (Taipale, 2016).

Though research has linked obsessive cognitions to negative affect, notably anxiety, it can be argued that this obsessional absorption functions as a dissociative defence in a similar way that experiential avoidance strategies - such a distraction or denial - function to prevent prolonged contact with unpleasant feeling states (Cludius et al., 2017; Kappes & Schikowski, 2013).

More specifically, the dispersive splitting that occurs as a result of obsessive cognitions can be understood as attempts at modulating *core affect* (Frewen & Lanius, 2015). The term core affect originates in the circumplex model of emotion where it represents, "the affective background of moment to moment experience…of oneself in the form of homoeostatic processes generally signifying basic degrees of arousal and felt (un) pleasantness" (Russell, 2005 as quoted in Frewen & Lanius, 2015, p.17).

When applied to the cognitive process of obsession, it can be assumed that predictable looping of 'affect laden cognition" - fear of contamination for example - function as an attempt to feel differently and alter one's sense of core affect and perceptive identity (Frewen & Lanius, 2015, p.17).

It can be argued that these repetitious, predictable and consequently inflexible cognitions and their associated affective states create what trauma theorists term, *inhibiting affect* (Ford & Courtois, 2013). Drawn from the emotion focused therapy protocol for treating PTSD, this term represents the milder negative affective states

that prevent the self from accessing and deepening core emotions (Ford & Courtois, 2013).

Emotionally focused therapy protocols suggest that qualities of reflectiveness, flexibility and clarity are notably absent in inhibiting affect feeling states (Ford & Courtois, 2013). Furthermore, empirical studies have similarly suggested that individuals with OCD display more difficulty in clarifying emotions and less flexibility in using emotional regulation strategies suggesting the presence of the principle characteristics of inhibiting affect feeling states (Keong et al., 2017).

It would then be logical to assume that the cognitive looping of affect-laden thoughts (obsessions) allow for a dissociation from core affect through maintenance of inhibiting affect feeling states.

Compulsions, the second component of OCD, serve a similarly dissociative function in the self. These behaviours are understood as, "repeated rituals or patterns of behaviour that the client feels compelled to perform in an attempt to control anxieties" (Zubernis & Snyder, 2016, p. 76). Compulsions within OCD symptomology are distinguished from those found in addiction related behaviours as individuals derive no pleasure from enacting ritualistic behaviours, they are instead used to counter the discomfort brought on by obsessional cognitions (Thomas & Drake, 2012). Resistance to performing compulsive rituals has been demonstrated to heighten anxiety and therefore, any attempts to eliminate or reduce ritualistic behaviours results in a significant increase in distress and hyperarousal (Thomas & Drake, 2012).

Like obsessive cognitions, it can be argued that compulsions serve a dispersive and dissociative function as they frequently involve high levels of absorption which

produce lapses in attention and consequently result in fragmentation of memory and perception (Giesbrecht et al., 2008). Furthermore, attention to enacting rituals is often all consuming and in severe forms of obsessive-compulsive disorder can take several hours to complete a day (Sanders & Wills, 2013).

Moreover, the cognitions associated with compulsive behaviours often invoke traits of 'fantasy proneness' - a dissociative mechanism – wherein a person knows that their ritual will not actually 'right' the cause of their anxiety but they feel compelled to do it anyway (Giesbrecht et al., 2008; Thomas & Drake, 2012).

If the dissociative mechanisms of obsessions modulate perceptive identity by preventing contact with core affect, the cognitive and behavioural traits of compulsive can be understood as dissociative mechanisms that work on the chronological level. The enactment of these ritualisations allow for the forgetting of emotional information not directly linked to the maintenance of the compulsion which enables a splitting of the self into separate parts (Giesbrecht et al., 2008). Functionally, the cognitive absorption required to enact compulsive ritualisation produces a state of dissociative disengagement that inhibits the, "true source of anxiety consciously being attended to" (Bowins, 2004, p.8).

Ultimately, both obsessions and compulsions function as dissociative mechanisms allowing for disengagement from core feeling states. As a result, these sets of cognitions and behaviours serve a regulative purpose as they involve a deliberate, "process of initiating, maintaining, modulating or changing the occurrence, intensity, or duration of feeling states…through effortful management of attention" (Eisenberg, 2000, p.137).

Harmful versus Helping: Coping and Defence Mechanisms

In the short term, the dissociative strategies of OCD may provide relief from prolonged experiential contact with uncomfortable core feeling states and serve to regulate responses to stressful or upsetting circumstances. However, research has consistently demonstrated that emotionally avoidant strategies lead to poorer emotional outcomes over the longer term (Kappes & Schikowski, 2013).

If OCD is to be understood as a dissociative defence, the line between defensive coping and harmful avoidance must be considered. In Vaillant's classification of defences dissociation is classified as an intermediate defence (Vaillant, 2014). This grade of mechanism typically involves moderate forms of cognitive distortions which are linked to lower levels of psychological and social adjustment compared to more mature defences such as intellectualization and sublimation (Vaillant, 2011). Further research indicates that frequency and level of awareness are key factors in determining whether a defence mechanism helps an individual to cope or harms them (Cramer, 2008).

When applied to the function of dissociative defences in OCD, it would follow that when obsession and compulsions are employed periodically to redirect awareness from painful core affect states such as loss or terror, the expression of OCD may serve as a helpful coping mechanism in instances where an individual feels overwhelmed by the task of processing painful emotional material. This is particularly relevant in relation to traumatic experiences wherein, "the individual's ability to integrate his/her emotional experience is overwhelmed" (Pearlman & Saakvitne, 1995, p. 60).

For example, in a situation where a mother may have experienced childbirth related-trauma, an obsessive-compulsive fixation could develop around keeping the infant clean. The maintenance of this loop provides a defensive function against

processing underlying painful emotional material which could prove overwhelming to a new mother tasked with the physically and emotionally demanding role of caring for an infant.

However, when the frequency of obsessional thinking and ritualisation becomes heightened, these mechanisms can quickly become great sources of pain and distress in themselves (Burchi et al., 2017). For example, when absorption into obsessional thinking intensifies, there can be a loss of awareness and rationality further intensifying the need to 'correct' the thought through ritualisation (Kroska, Miller, Roche, Kroska & O'Hara, 2018).

Most importantly, deepening our understanding of the coping functions implicit in OCD related symptoms demonstrates that these cognitive and behavioural patterns are not inherently pathological. However, in parallel these strategies must be understood as short term coping mechanisms than can at best allow the individual to delay the intensive and often painful work of integration (Ford & Courtois, 2013). Trauma theorist Bessel Van der Kolk aptly articulates the particular costs that prolonged use of dissociative strategies incur to self-hood with, "As long as you keep secrets and suppress information, you are fundamentally at war with yourself…The critical issue is allowing yourself to know what you know. That takes an enormous amount of courage." (Van der Kolk, 2014, p. 13).

Chapter Three

Implications for treatment

To recapitulate, in response to the emerging lines of research demonstrating strong connections between trauma exposure and OCD, it was proposed that the obsessional cognitions and compulsive behaviours serve as dissociative defences allowing for the disengagement from distressing core emotional states. At present, the dominant treatment protocols of cognitive behavioural therapy and pharmacotherapy (SSRIs) rely on a purely symptom focused approach - meaning treatment is directed towards reducing and ideally eradicating clinically significant symptoms (Burchi et al., 2018). Underpinning this perspective is the recognition that these symptoms are inherently pathological and driven by malfunctioning circuitry in the brain or in irrational processes of appraisal (Fava et al., 2014; Salkovski, 1999). When considered in the context of trauma exposure, these assumptions then become highly problematic.

Newer clinical viewpoints that can appropriately respond to the complexity of this condition are necessary. Both internal family systems therapy and person centred therapy modalities provide platforms through which the troubling and distressing aspects of the self can be compassionately engaged rather than blanked out (Rogers, 1961 ; Schwartz, 2013). In opposition to cbt and pharmacotherapy approaches these modalities regard acceptance as the main precursor to transformation and rely on the innate resources of the self to bring about greater integration (Schwartz, 2013; Wilders, 2006).

A reorientation towards the non-pathologizing stances of these modalities for OCD is not purely based on philosophical reasoning but is grounded in increasing empirical

findings demonstrating the effectiveness of acceptance-based therapies for symptoms of trauma-related disorders (Kroska et al., 2018)

Internal Family Systems Approaches to OCD

The internal family systems model provides an expansive framework capable of addressing the expression of OCD as a dissociative defence. IFS is based on the premise that the individual is a system of interacting multifaceted and separate parts (Schwartz, 1995). These parts are classified into two different entities: sub-personalities or parts which are aspects of the personality and the *self* which represents a core innate state of each person characterized by calmness, security, wisdom and confidence (Carlisle, 2015 ; Riskin, 2013).

The primary goal of ifs is then to work with individuals to discern, differentiate and value their separate parts to achieve greater internal harmony (Carlson & Dermer, 2017). In the ifs self-structure, the three main sub-personalities, *managers*, *firefighters* and *exiles* are each ascribed with a unique set of protective responsibilities to maintain a state of balance in the system.

In the context of OCD, the obsessions and compulsions can be understood as fire-fighters which are tasked with the role of protecting the system from pain by introducing cognitions and behaviours that inhibit contact with core affect feeling states (Carlisle, 2015). In ifs protocols for PTSD, the firefighters are similarly understood as activating numbing behaviours such as over-eating, ruminating, drug and alcohol use (Jones & Lucero, 2017).

The painful feelings and material that are obscured through the dissociative cognitions and behaviours of these firefighter parts are termed the exiles (Carlisle,

2015). These exiles are tasked with the role of remaining hidden as the potency of their pain is understood as a threat to the harmony of the system (Jones & Lucero, 2017).

IFS theorists further suggest that when individuals encounter overwhelmingly painful or threatening experiences as is often the case with trauma exposure, that the protective sub-personalities are forced into more extreme roles (Schwartz, 1995). This process involves parts being forced, "out of their naturally valuable functions and healthy states…which makes them lose trust in the leadership of the self" (Schwartz, 2013, p. 80). This process applies to the onset and intensification of OCD related defences where obsessive and compulsive parts progressively take on more extreme protective roles in the system which ultimately induces more severe forms of dissociation and disconnection from the core self.

The central aim of working within the ifs framework for OCD is to reconnect these protective parts into a trusting relationship to the self. In this context, the self can be understood as an inner state of spacious well-being (Schwartz, 2013). The IFS framework holds that the self has an irreducible and innate wisdom about how to be in relationship to these protective parts (firefighters and exiles) of the self-system. The healing process in OCD is then essentially understood as a process of reconfiguring the inner attachment patterns to allow the obsessive and compulsive parts to become securely attached to the self (Schwartz, 2013). When individuals with OCD can consistently extend acceptance and compassion to these various parts - specifically those frozen in time and split off from conscious awareness - these parts become transformed and are able to release their overriding need to control and defend the system (Schwartz, 2013). The process of transformation involves a shift into a state of

"self-leadership" where all aspects of the system specifically the obsessive and compulsive parts feel valued and understood by their natural inner leader, the core self (Schwartz, 2013, p. 808)

P**erson Centred Approaches to OCD**

An alternate and equally relationally oriented therapeutic modality capable of addressing the complexity of OCD is the person centred therapy model. Historically, person centred practitioners have largely resisted adopting the nomenclature of psychiatric and psychological interventions which has mostly sidelined the approach from the clinical literature of these fields (Joseph, 2004). As a result, there are few available texts outlining the application of person centred theory for OCD or for any trauma related conditions.

Person centred therapy theorizes that by creating new conditions of relationship, the inherent growth force (the *self-actualizing tendency*) can be unblocked and encouraged allowing individuals to guide their way to greater integration (Mearns & Thorne, 2008). At its core pct theory holds that a growth promoting climate is created by the co-existence of three essential qualities: congruence of the counsellor, the counsellor's ability to offer full acceptance and finally a counsellor's empathic understanding of the world of the client (Rogers, 1961).

The *fragile process* theory developed by Margaret Warner is a more recent interpretation of these original core conditions (Warner, 1998). In the context of OCD, Warner's theory provides a practical protocol for engaging with clients experiencing extreme forms of dissociative processing (Warner, 1998). Within this approach it is theorized that clients using dissociative processes frequently experience core issues at either very high or very low levels of intensity and consequently

experience greater challenges either connecting or disconnecting from emotionally significant material which is termed *fragile processing* (Warner, 1998, p. 375)

Individuals with OCD can be understood as engaging in fragile processing as the obsessions and compulsions of this disorder are used to diminish the intensity of core affect states. Additionally, Warner suggests that clients who use dissociative defences respond particularly well to the pct approach because it permits high levels of client control over the content, style, and speed of the therapeutic process (Warner, 1998).

The crux of Warner's protocol states that when therapists remain empathetically connected and attuned to clients experiencing dissociative processes that the self-actualizing tendency will prompt the dissociated material to emerge at the client's own self-determined pace (Warner, 1998).

As previously noted, the dissociative cognitions and compulsions of OCD can often follow unusual logic which can prove challenging to the therapist's ability to understand and maintain an accepting stance. When engaging with clients during dissociative self-states, Warner stresses the importance of using the client's own descriptive language as faithfully as possible (Warner, 1998). Warner cautions that therapists' attempts at broadly rephrasing or clarifying can often be interpreted as efforts to correct perception which can easily disturb the client's sense of being emphatically understood (Warner, 1998).

Ultimately, for clients with OCD the change process within this approach is understood as cumulative. As therapy progresses and as clients continue to be met with an empathic and soothing therapeutic presence, their self-directed growth process will increasingly allow them to hold more intense emotions in awareness

without feeling overwhelmed (Warner, 1998). As their capacity to connect to these emotional states strengthens, the need for dissociative mechanisms of obsessional thinking and compulsive ritualisation consistently decreases.

A final construct which emerges out of the Person Centred tradition and which is highly relevant to the expression of OCD is the concept of *configurations of self* which can be understood as, "parts that have evolved to manifest different themes within the self" (Mearns & Thorne, 2008, p. 33). The obsessions and compulsives associated with OCD can be understood as protective configurations of self which emerge to protect the self-structure from what is perceived as threatening emotional material (Joseph, 2004).

In the context of OCD, the disorganisation of the self-structure occurs when the obsessions and compulsions (configurations of self) distort the inner experience so greatly that the individual is left in a place of extreme incongruence. By this it is implied that the individual is actively and nearly totally denying their self-experience. Therefore, the healing process in OCD is understood as a creative process of *congruent reintegration* which involves forming new configurations of self to accurately symbolise internal emotional states (Joseph, 2004, p. 109 ;Tolan & Wilkins, 2012).

In more practical terms this congruence implies accurate representation in conscious awareness of underlying feelings and also applies to an individual's way of appropriately expressing these same feelings (Joseph, 2004). Ultimately the healing process of OCD extends far beyond just the eradication of symptoms but is instead a fundamental process of realignment between ones' self-experience and with one's way of being in the world (Tolan & Wilkins, 2012).

Limitations and Further Discussion

The proposition that OCD serves as a dissociative defence was presented in response to new lines of inquiry suggesting linkages between trauma and OCD. While a comprehensive review of recent trauma literature was beyond the scope of this paper, the absence of a unifying definition of trauma or traumatic exposure across these clinical and empirical studies limits the generalizability of their claims. Moreover, many of these studies utilized self-reported retrospective data which introduces a strong potential for bias and used non- specific parameters regarding timing of the traumatic events (Fontenelle et al., 2012 ; Kroska et al., 2017)

Additionally, further discussion of the causation versus correlation debate in relation to trauma, dissociation and ocd is needed as certain lines of research indicate that adults with psychosocial problems may also be more prone to recalling experiences of complex trauma (Widom, Raphael & DuMont, 2004).

Lastly, the consideration of OCD as a dissociative strategy was limited by the absence of an overarching psychosocial model of trauma and traumatic distress. To be theory coherent, the proposition that OCD is a dissociative defence cannot be formulated in isolation and must be integrated into a broader theory of trauma and/or trauma related conditions.

Conclusion

The proposition that Obsessive Compulsive Disorder is a dissociative defence was formulated in response to both the emerging research demonstrating linkages between trauma and ocd and in reaction to the well documented weaknesses within current treatment protocols. To summarize, by first examining the outcome research of pharmacotherapeutic and cbt approaches for this disorder it was demonstrated that these intervention styles were frequently ineffective. Newer lines of research examining the social-environmental conditions in the expression of OCD were then considered revealing strong associations between OCD and traumatic exposure. Without any current psycho-social models of OCD, the substantial evidence within trauma research demonstrating that dissociative tendencies are frequently used to attenuate the impact of traumatic was then used to guide the formulation of the proposition that OCD serves as a dissociative defence.

Using constructs from the circumplex model of emotion and emotionally focused therapy it was demonstrated that the cognitions and compulsions of OCD inhibit contact with core feeling states and modulate affect. Further discussion then examined the distinctions between the harmful and helpful coping strategies in the context of OCD as a dissociative defence and the need for non-pathologising stances towards the symptomology of this disorder.

The practical clinical implications were then considered where internal family systems and person-centred therapy were shown to be valuable intervention responses as a result of their acceptance-based approaches and their pluralistic conceptions of self-hood. Finally, it was acknowledged that the proposition of this paper cannot be made in isolation and must be integrated into a comprehensive psycho-social model of

traumatic distress to become theoretically coherent. Ultimately, it is hoped that the proposition put forth in this article is a step forward in our current conceptualisations of OCD and that it highlights the need for phenomenologically based practitioners to conduct further research and push the existing lines of theory to allow for richer conceptualisations of this disorder

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