All Tangled Up: When OCD Has Multiple Layers

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Multiple layers of OCD, or OCD that involves obsessing about the OCD treatment, is a phenomenon I see frequently. It contributes to patients' difficulties in treatment, yet often goes unrecognized.

Most readers of this article are well-acquainted with the reinforcement cycle that maintains OCD and the treatment interventions that disrupt the cycle. The reinforcement cycle consists of a "what if" obsessional thought followed by avoidance and neutralizing thoughts or acts that give fleeting relief but strengthen the anxiety-laden "what if." OCD treatment consists of cessation of neutralizing thoughts or acts, called Response (or Ritual) Prevention, and the challenging of behavioral avoidance, called Exposure. Treatment also emphasizes the acceptance of uncertainty about the obsessional "what if."

In addition to these concepts, there are fundamental assumptions about treatment that patients grapple with before engaging in a challenging treatment program. These fundamentals include assumptions about accuracy of diagnosis, best treatment options, and clinician competence. The second layer, or what I call the "meta layer," of obsessive worry focuses on these basic assumptions that are necessary for a patient to engage in treatment.

What follows are lists of common "what if" worries comprising the meta layer of symptoms. Obsessive worries regarding treatment outcome and the treatment itself include the following: What if therapy does not work? What if this is not the right medication? Is a behavioral or cognitive approach better? What if I am doing the exposure assignments incorrectly? What if I cannot do the treatment? What if I forget or misunderstand what the therapist said? Particularly challenging obsessive worries about the outcome of treatment include the following: What if I become suicidal from treatment? What if I do not get better? What if I have to live like this forever?

Obsessive worries about the accuracy of the diagnosis include the following: What if I am diagnosed with OCD erroneously? What if it (e.g., the contamination) is "real" (not OCD)? What if this time it is not OCD? What if my OCD is different? What if this ordinary behavior is OCD? Obsessive worries about the therapist include: What if the therapist does not have enough experience? What if he or she does not really care about me? What if the therapist does not really understand me, my symptoms, my situation, my culture, my religious beliefs, etc.? These lists are not exhaustive, but are some examples of the meta layer of obsessive worry.

Neutralizing thoughts and behaviors reinforce the "what if" worries about the assumptions necessary for treatment. Compulsive note-taking reinforces worry about forgetting what the therapist said. Patients directly or indirectly elicit reassurance about the correctness of their diagnosis and treatment approach and about the qualifications of their clinician. Patients scrutinize therapist behavior for evidence of genuine concern. Compulsively trying medication after medication can reinforce worry about taking the wrong medication. Patients struggle to perform exposure exercises perfectly. They analyze approaches to therapy, see several therapists simultaneously, and shop from therapist to therapist in an effort to find the right therapy. Self-reassurance, advice-seeking, and analyzing also reinforce obsessive worry about the assumptions necessary for treatment.

One reason the meta layer of obsessive worry goes unnoticed is that these concerns are reasonable. In contrast to the dramatic presentation of most obvious OCD symptoms, which patients usually experience as irrational or excessive, patients experience these worries and efforts to neutralize as reasonable. Clinicians also experience these questions from their patients as reasonable and respond with information intended to alleviate the patient's concerns. Unfortunately, by responding in this way without considering the obsessive nature of the worry, the clinician unwittingly reinforces the obsessive worry.

Another reason the meta layer is reinforced inadvertently is that clinicians are eager to explain and justify their treatment recommendations. They might also be eager to promote the superiority of their own skills, training, or approach. Although sometimes helpful, such explanations can reinforce a meta layer of obsessive worry about the adequacy of the treatment approach or about the competence of the clinician.

Even when the clinician recognizes the presence of a meta layer, she may find it uncomfortable to respond in a way that disrupts the cycle of obsessive worry. For example, imagine a patient who has obsessive worry that he will never have relief from severe symptoms. In order not to reinforce the worry, the therapist would need to resist the inclination to reassure the patient. Rather, the therapist would need to say something difficult, but honest, such as, "There is a chance that you will never have the relief that we both want you to have."

Another reason for difficulty in recognizing the meta layer is that the patient may not be disclosing this layer of symptoms. For example, the patient may fear insulting the clinician by expressing doubt about the treatment or about the clinician's qualifications. Because only the obvious OCD symptoms were the reason for seeking treatment, the patient may not recognize these worries as appropriate to discuss in treatment. Rather, the patient may be reassuring himself or seeking information or advice about the worries outside of therapy.

I give extra consideration to the possibility of a meta layer if my patient's symptoms are not improving or are getting worse no matter what exposure exercises we try. This can arise when the meta layer includes the compulsive need to perform the exposure exercises in exactly the right way. Sometimes, this need is associated with obsessive worry about not getting better. The problem here is that the exposure exercises for the obvious OCD symptoms have become a way of neutralizing the meta layer of obsessive worry about not getting better. In other words, the treatment of the obvious layer of symptoms is reinforcing the meta layer of symptoms.

I also consider the presence of a meta layer if both patient and therapist are trying hard but are feeling frustrated. When working as intended, Exposure and Response Prevention are not frustrating for the therapist or the patient. Therapy might feel frightening, upsetting, challenging, or exhilarating; but rarely frustrating. Frustration is a feeling that comes from engaging in the endless cycle that maintains OCD and obsessive worry. When the patient and therapist are feeling frustrated, the therapist may be unintentionally neutralizing the meta layer, causing the therapy to get all tangled up.

The general idea in therapy is to disrupt the reinforcement cycle of the meta layer of symptoms, together with the cycle of the obvious layer. A clear understanding of the reinforcement cycle shared by the therapist and patient is vital. "What if" worries and efforts to avoid and neutralize associated with the meta layer are identified. Identification of other "what if" worries that may be present is also helpful. The patient and therapist agree not to reinforce the obsessive worries. The therapist points out examples of reassurance questions and other efforts to neutralize, as they arise. The therapist will need to remind the patient gently of the importance of learning to accept uncertainty and of the reasons the therapist is not providing comforting, neutralizing responses. This cessation of neutralizing is Response Prevention for the meta layer of obsessive worry about the treatment. Making decisions about one's own treatment in spite of uncertainty is Exposure for this layer.