Co-Compulsing: Seductive and Unproductive Therapy Conversations

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Disclosures

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*What Every Therapist Needs to Know About Anxiety Disorders: Key concepts, insights, interventions.* (Routledge)
Cases that go nowhere

- “I know you are right, but I just can’t help thinking about it.”
- “I know it in my head but apparently not in my heart.”
- “I tried what we talked about but it made no difference.”
- “I thought of another issue that we didn’t discuss.”
- “I just can’t get over this--it keeps coming back.”
- “I had decided, but then I got worried I was making a terrible mistake.”
- “I thought I was sure, but then my old fear about offending God popped up.”
- “Yes, but.......”
Our Challenge as Therapists: Usually....

• Our patients and their loved ones have tried everything obvious in the way of problem-solving well before they get to us.

• We need to offer something different.
The Thesis: A Work in Progress

• With patients who are chronic worriers, whether they have GAD or OCD or both, it is often surprisingly counterproductive to address the content they bring in each week.

• Creative and interesting conversations can inadvertently maintain and even escalate the dynamic of worry by serving as cognitive compulsions. This process can be subtle.

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The Thesis: Co-Compulsing

• Co-Compulsing is the anxiety equivalent of the empirically validated concept of co-rumination in depressed states

• Working at the meta-level with stuck, repetitive and circular loops is an effective alternative to co-compulsing with the patient.
Co-Compulsion: Therapist Temptation

- Obsession frequently presents as interesting “issues” and we enjoy exploring them.
- During these discussions, there is an illusion of being helpful, as short term anxiety-reduction occurs. Patients often leave the session feeling good.
- If neither patient nor therapist recognize the problem, it can go on for years with the illusion of making progress while suffering continues.
Cognitive Compulsion Examples: Repeatedly telling oneself that

• “I have a plan: I will discuss this issue with lots of people to help me decide”
• “Self-reassurance: My therapist thinks it is unlikely that I will drive off the bridge so I remind myself of that as I am driving”
• “I just need one more check to make sure.”
• “Now I am certain this is the right choice.”
• “Praise the Lord, he will take care of me.”
Co-Compulsion

• The therapist (or friend) participates in conversations which are essentially compulsive activity:
  – Reassurance in the quest for the feeling of safety
  – Analysis with the hope that insight will stop the worry
  – Refutation to make the distress go away
  – Cognitive checking to try for the feeling of certainty
  – Treating the content as if it is a message about self or danger or the nature of reality
Similar Functional Relationships in both OCD and GAD

• OCD
  – Behavioral compulsions
  – Cognitive compulsions

• GAD: worry thoughts both raise and temporarily lower anxiety

• Both are phenomenologically and structurally similar, both can involve mental compulsion.

• Both are functionally equivalent.

• OCD and GAD both pull for co-compulsion.
A Continuity from OCD (Behavioral) to OCD (Mental) to Worry (OCD Lite)

• The functional relationship is precisely the same
• The content of thought can vary wildly, from ordinary to bizarre
• We conceptualize mental OCD as ego dystonic worry
• Ego dystonic and ego-syntonic content are treated in the same manner
Co-Compulsing

• Has the wrong meta-cognitive orientation by joining with the patient in appraising content as meaningful, urgent or productive

• Often suggests various avoidance aka “coping” methods to help get rid of or solve the concern

• Serves as negative reinforcement, thereby maintaining the worry dynamic
Range of Bizarreness in OCD/GAD

- Will my child be okay?
- Am I a good person?
- Did I get the best deal on this purchase?
- Could the doctor have missed something?
- Could something bad happen?
- I can’t concentrate/remember/think properly.
- What if this food is contaminated?
- What if I did something bad I don’t know about?
- What if I locked a child in the refrigerator?
- What if this means I am possessed by Satan?
OCD Rituals (Compulsions): Most Can Be Entirely Mental

- washing
- checking
- repeating
- **counting**
- **correcting**
- hoarding
- **avoiding**

- ordering
- undoing
- **monitoring**
- **neutralizing**
- **seeking reassurance**
- **mental checking**
- analyzing

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Compulsions can be Subtle

• How is a compulsion defined?
• How is a compulsion identified?
• What is the phenomenology of OCD cognitive compulsions?
• What is the phenomenology of GAD worry states?
“Pure O” OCD: Not a Useful or Valid Concept:

• Obsessions and Compulsions are defined by their Functional Relationship to each other.
• Obsessions raise anxiety; Compulsions temporarily lower anxiety.
• This occurs independent of content and whether the compulsion is behavioral, entirely cognitive, or some mixture of both.
• So look for subtle and all-cognitive compulsions
With Obsessive Worry

• The question is the obsession. This question is unanswerable. The quest is for a response that eliminates doubt.

• The attempt to answer the question is the compulsion (often called rationalizing, analyzing, problem-solving, affirmations, trying to think positive)

• Successful treatment involves refusing to answer or even engage with the question
  – “what if” my child never finds a job?

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The Nature of Worry

- Unwanted and repetitive thinking
- Non-productive worry does not produce an actionable plan; it is not problem-solving
- Feels not under conscious control
- Content can be ego-syntonic (GAD) or ego-dystonic (OCD)
What Makes Worry Problematic and Recurrent?

- How the thoughts and feelings are appraised
- Thought control strategies that fail
- Safety behaviors involving avoidance (both emotional and behavioral)
- Meta-cognitive beliefs
- Anxiety sensitivity: meta-worry
- Physiological factors that make the mind sticky, including mood and biological substrate

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Worry Has Two Components

• The first part of worry is the anxiety or distress-raising question. (the O)
• The second part of worry is the attempt to deal with it and make the distress go away. (the C)
• The two parts oscillate back and forth repetitively over time
• The more ego-syntonic the content, the more true and important it seems.
The “Question”

• Seems like an issue or a problem to be solved
• Usually involves safety, morality, ambiguity, doubt or responsibility
• The illusion of certainty is sought
• It is accompanied by a jolt, spike or whoosh of affect
• It seems to beg for attention and impact
The “Answer”

• ANYTHING that is an attempt to engage at the level of content in order to reduce the anxiety or distress of the question can function as a negative reinforcement. It is a cognitive compulsion.

• It often looks like refutation, analysis, problem solving, re-framing or distraction.

• Your brain is not your friend (Steven Hayes)
AVOIDANCE
RESISTANCE
NEUTRALIZATION

FEAR

SENSATIONS
THOUGHTS
MEMORIES

FEAR

MISINTERPRETATION
AS DANGEROUS

FEAR

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Meta-Worry
(Worry about Worry)

• I will go crazy if I can’t stop.
• I can’t stand this.
• I am hurting my immune system/ heart/ general health/mental health
• What is wrong with me? Why can’t I control this? Why am I such a loser?
• Is my medication wrong?
• I am such a downer, everyone will reject me...

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Metacognition

• Cognitive factors that appraise, control and monitor thinking itself
• The content of the thoughts is not the issue.
• Metacognition accounts for the attitude towards the thoughts, the importance attributed to them and the affective and behavioral reactions to the thoughts

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Meta-Cognitive Beliefs Must be Challenged

- Every thought is worth thinking about
- Every thought has meaning or implication
- I am morally responsible for my thoughts and I am responsible for any outcome if I have imagined it
- Not feeling certain about something signals danger
- Not remembering clearly signals danger or an urgent need-to-know
- Worry is problem solving or preparation for calamity.
- Worry keeps me in line or keeps me or others safe.

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Challenging Meta-Cognitive Beliefs

More Beliefs About Thoughts

- I must be free of unwanted thoughts to be happy or to do what I want to do.
- Thought-action fusion: thinking about doing something is morally equivalent to doing it or makes it more likely to actually happen.
- One ought to be able to control one’s thoughts
- If distraction does not work, try harder to distract
- Replace negative thoughts with positive thoughts and you will feel better
- If a thought brings a feeling, it is an urgent matter.
- Ignoring thoughts is unhealthy. Mental health means no distressing thoughts.
Challenging Meta-Cognitive Beliefs
Any Engagement is Potentially a Trap

- Example: The presidential press conference
- Feeding the baby tiger
- The rules are stacked against you. You cannot win (Wilson)
Dysfunctional Cognitive Control: Strategies That Don’t Work

• Just relax, don’t be nervous! Exert more willpower! (Paradoxical effort)
• Stop worrying, you will make yourself sick (Meta-worry and punishment)
• Everything will be okay. Trust me. I promise. (Reassurance)
• Calculate probabilities (Self-reassurance)
• Don’t think about it. Think about something else. (Distraction)
Cognitive Compulsions Can Masquerade as Helpful

- BUT you never find out what would have happened had you not compelled (feedback and mastery and natural habituation are averted) AND
- Coping skills of all kinds actually function as negative reinforcement. They may immediately reduce anxiety but they are “addictive”. Coping skills are not a goal. They block learning to tolerate discomfort and reinforce urgency and avoidance.
- Cognitive compulsions and co-compulsions can be incredibly subtle. They are defined by their functionality not their content.
More Strategies That Don’t Work

• Think about happy thoughts or affirmations (Suppression)
• Have more faith; pray about it (Ritualized. prayer)
• Stay positive. Negative attracts negative (Magical thinking)
• Cut out sugar and caffeine, try this tea, exercise it away (Lifestyle changes)
More Strategies That Don’t Work

• Avoid stress. Change jobs. Take a vacation. Dump the boyfriend (Misunderstand the role of stress)
• Figure out why you are stuck on this. Relate this to your childhood or your personality (Insight alone)
Ironic Process: When Distraction Breaks Down

• Intentional Distraction (conscious)
• Monitoring for Intrusions (unconscious)
• Works under low stress conditions
• Fails under higher stress (read: more important) conditions
• At this point, intrusions must be **actively allowed**
• Examples (bum at the party, introducing yourself while having anxious thoughts)
If Distraction, Reassurance or Information Works

• Great! This is NOT co-compulsing!
• But then the thought will not re-emerge in the same or slightly different form
• The thought will not continue to “torture” the person
• The worry will likely be forgotten or judged uninteresting or not worthy of further attention
When a Simple Response Does Not Work (Try easy once!)

- It is easy to be drawn into co-compulsing
- Withdraw engagement at the level of content or meaning of the thought
- Review labeling of the thought
- Hold the line on “sneaky” returns to content
- Move to the level of meta-response: “You are having the thought that....”
- Metaphors are helpful here
Paradoxical Effort:
What you Resist Persists

- Many sincere patients expend all their emotional energy in trying to change their thoughts, control their minds, relax their bodies, affirm their positivity, relieve stress, wrestle to fix the content of their thoughts.
- This effort works backwards.
- And the more desperate the effort is, the more backwards they go.
- It is very easy to join them in the same efforts.
Reassurance Compulsions

- Pestering or “dependent” behavior
- Sharing responsibility for consequences
- “Urge to confess” compulsions
- Interpersonal or internet checking
- Often misperceived as AXIS II trait
- May be internal or interpersonal or both
- May turn into “co-compulsion” with friends or therapist
- Reassurance junkies will never get enough

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Case Examples of OCD misdiagnosed as “issues”:
Co-Compulsion Temptations

- Woman with “marital issues” (pathological doubt)
- Philosophy student with delusions (existential OCD)
- Fears of intimacy/“commitment phobia” (reverse BDD)
- Emerging “postpartum psychosis” (what if I go crazy)
- Iraq war vet with cognitive checking compulsions (Memory checking compulsions)
- Refractory “suicidal ideation” (what if I go crazy)
- Sexual orientation “questioning” (HOCD)
How Do You Know it is OCD?

• An OCD thought is identified not by the content of the thought but by how the thought FEELS and how the thought ACTS.
• Precisely the same thought could be OCD or not (even in the same person)
• If a single simple reassurance from a credible source, internal or external, works to move the thought along and reduce the FEELING of needing to address it, then it is likely not OCD
Dealing with Uncertainty

• Can you know FOR SURE that it is OCD?
• Certainly Not. There is a leap of faith involved.
• But OCD Feels like it is a real and pressing issue.
  • Feelings are not facts
A Particularly Problematic Issue: Interpretation of Content

• An obsession is the opposite of a wish. Content is chosen because it is the most resisted.
• This is an absolutely critical issue in the treatment of obsessions.
  – If you confuse a true obsession with an impulse or a wish, you will make the OCD sufferer worse.
  – Interpretation of an intrusive thought in OCD as a meaningful outcropping of an unconscious wish is dangerous.
Content is “chosen” by OCD according to the “most resisted”

- Scrupulosity does not occur in atheists. OCD scrupulosity symptoms stick by virtue of being taboo and fought against.
- Fear of suicide occurs in people who love life (“suicidal thoughts” are ego-dystonic in OCD); these need to be distinguished from suicidality in co-occurring depression in OCD and traumatized states.
- People who worry about blurting are polite people.
- Harming obsessions happen in people who value safety and abhor violence. (Harming ruminations and revenge fantasies can be part of PTSD: this is different.)

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What to Do Instead

- Meta-level work: Observe, don’t engage
- The Attitude of Acceptance is best taught by metaphor
Attitude of Acceptance Step 1: Expect Such Thoughts

• The mind is sticky doubts arise easily and stick.
• If there is novelty, ambiguity, fatigue, arousal, hunger, conflict or excitement, worry questions come up.
• HALT and IFS
Attitude of Acceptance
Step 2: Label as Thoughts, Not Issues

• Move to the mindful meta-level and the “wise mind”.
• Is this an OCD thought? Is this an unanswerable question? Is this line of thinking productive?
• Grayson’s gun test
• Hyman’s color test
Attitude of Acceptance
Step 3: Surrender the Struggle

• Do not engage with the question
• Do not try to make the question go away
• Do not explore what it means or implies
• Do not try to fix anything
• Thank your brain for doing its job
Step 4: Actively Allow the Thoughts

And proceed to do what is next
Attitude of Acceptance
With Every Step:
Tolerate the Uncertainty

• Maybe it is not just a thought
• Maybe there is something you should be doing
• Maybe there is something you are missing
• Maybe your worst fears will be realized
• Maybe this way of doing therapy won’t be helpful
Metaphors

- The waterfall
- Whack-a-mole
- Tissue demo
- Bum at the party
- Chess board
- Bug on the windshield
- Scary movie
- Leaves on a stream
Exposure Work May be Needed

Make sure you are exposing to
1. the question (not the answer), and
2. the uncertainty

Examples:
• Post-it notes “Life could well be meaningless” all over the house.
• Songify “I could have made a terrible mistake.”

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Psychodynamic Work: Where Does It Usually Fit?

• **IN RELAPSE PREVENTION PHASE, AFTER SYMPTOM MANAGEMENT IS ACHIEVED and AFFECT TOLERANCE IS AVAILABLE**

• To understand how cognitive distortions came about and to deepen one’s relationship to and compassion for the self and others.

• To increase psychological flexibility and value-driven action

• To understand what behavioral patterns, affects, issues and memories tend to re-sensitize

• Co-compulsing can look like good psychodynamic work but it ultimately goes nowhere, and prolongs symptoms.

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What is the Function of the Question?

- Is it an attempt to bring an important emotional issue forward that needs to be faced and explored? Is it repetitive attempts to grasp and deal with something that is hard to assimilate? Is it actually unfinished business?
- OR is it serving as a blockade against emotional processing, or as random hiccups of the mind because of general arousal or mood?
- AND is it fueled and maintained by anxiety sensitivity, false meta-cognitions and compulsive attempts at lowering anxiety?
And finally,

• Thoughts not dreaded or resisted or entertained will eventually become disempowered, less sticky, less frequent and intense, and take their proper place in the flow of consciousness

• The key is to change the relationship with the thoughts and not the thoughts themselves. The changes the way the therapy is conducted.
For Further Information

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- What Every Therapist Needs to Know About Anxiety Disorders: Key concepts, insights, interventions.