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Sasha Pansovoy
An Exploration of the Relationship of
Obsessive-Compulsive Disorder Symptoms
And Traumatic Experiences in Adult Clients

ABSTRACT

This qualitative research study explored clinicians' perspectives on the association between Obsessive Compulsive Disorder and trauma in the treatment of adult clients. Using both content and narrative analysis, the study examined whether OCD symptoms are reminiscent of the clients' traumas. Nine clinicians were interviewed and presented narratives of clients who have experienced traumatic events and OCD. Key findings revealed that (1) 10 out of the 12 clients presented were abused as children; (2) OCD symptoms were perceived as coping strategies; (3) the majority of discussed clients were cisgender males; and (4) OCD symptoms of the clients reflected past traumas. Treatment considerations for the simultaneous experience of OCD and trauma were examined. These findings affirm a need for further research regarding the connection between OCD and trauma. Recommendations include the potential development of treatment modalities, which bridge multiple theoretical frameworks in clinical practice that best works for the client.

**AN EXPLORATION OF THE RELATIONSHIP OF OBSESSIVE-COMPULSIVE
DISORDER SYMPTOMS AND TRAUMATIC EXPERIENCES IN ADULT CLIENTS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2017

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To my sister, Aviva. Thank you for your love, humor, and warmth during this time, and always. You inspire me in your inquisitiveness and creativity.

Paul, thank you for your patience, support, and love. You have and continue to provide a holding space for my passions, goals, and deepest fears.

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To my fellow survivors: we are resilient creatures, do not believe anyone who tells you otherwise. Day in and day out, we are doing our absolute best amidst chaos. I hold a profound sense of gratefulness to the survivors I have been honored to work with over the past seven years. I am forever humbled by your stories, and hope that I provided a supportive ear in the course of your personal growth and healing, and continue to for others.

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CHAPTER I

Introduction

According to the Posttraumatic Stress Disorder (PTSD) Alliance (2016), over two-thirds of the American population has experienced trauma. Trauma can impact one's ability to perform and engage in daily tasks, as well as one's executive functioning, emotional health, concept of self, and physical health. Traumatic experiences and events have been studied; potential diagnoses include stress disorders, eating disorders, anxiety disorders, personality disorders, dissociative disorders, and psychotic disorders. However, there is a gap in the research exploring the relationship between obsessive-compulsive disorder (OCD) and traumatic experiences. The purpose of this study is to explore clinician's perceptions of any association between OCD and traumatic experiences in adult clients and whether those symptoms bear meaning regarding the experiences of trauma. The following reviews the literature and methodology used in the study.

Literature Overview

The majority of research surrounding trauma predominantly has focused on the way trauma is reflected through various diagnoses, and few studies have investigated the connections between trauma and OCD. There is not a large body of literature that makes clear connections between OCD and trauma or examines the potential meanings behind the OCD symptoms. While the existing research is limited, it does present some possible correlations between OCD symptoms and traumatic experiences (Wang, Wang, Xu, Zhang, & Xiao, 2011). Several studies highlight the strong correlation between childhood trauma and OCD, and a quantitative study reports that individuals who experienced trauma were much more likely to have OCD (Wang et

al., 2011). More specifically, additional studies have found a positive correlation between childhood sexual abuse and OCD (Caspi, Vishne, Sasson, Gross, Livne, & Zohar, 2008).

Case studies that were conducted by de Silva and Marks (2001) were utilized to gain a more in depth understanding of the connection between trauma and OCD. Intrusive thoughts were specifically noted as the similar symptom of both OCD and trauma. The case studies briefly discussed the deeper meanings behind particular OCD symptoms, and the authors recommended an assessment of trauma while assessing for OCD. Because there may be deeper meanings behind OCD symptomology, these authors recommended that other treatments should be made available.

Methodology Overview

Based on the existing literature on this topic, the current research study explores the following overall question: *What are clinicians' perspectives on the association between OCD and trauma in their treatment of adult clients, and how do the symptoms of OCD and trauma reflect the traumatic experiences?* This qualitative study explored nine clinicians' perspectives on this question and examined whether symptoms of OCD bear meaning to the clients' experiences of trauma. The qualitative method was the optimal choice for this study because it provided a platform for clinicians to discuss their clients' individual experiences of trauma and OCD.

My interviews were focused on the case studies that the clinicians presented, as well as other relevant experience and critical background information about the clinicians. Details of their practice and work surrounding trauma were incorporated into the interview. All interviewed clinicians were required to be trauma-informed, experienced with a minimum of one year post licensure, and must have had at least one client who experienced OCD and trauma.

Over the past six years, I have been involved with various organizations that supported trauma survivors and raised awareness of intimate partner violence. Through those various experiences, connections were created, and I was introduced to social workers who work for and closely with those organizations. As a result of that background, I was connected to the trauma-informed community.

Based on my past professional experiences with the trauma-informed community in Massachusetts, I used a snowball method to gather my participants. I also reached out to other clinicians in the state through the Smith College School for Social Work Alumni Facebook page. I interviewed the clinicians in their office or a location of their choosing. Further details about the methodology will be discussed in Chapter III.

Relevance to Social Work

Despite the continued growth of traumatic studies, there is deficit in the investigation of the connection between OCD and traumatic experiences. As social workers, it is essential that we provide the most relevant and current treatment possible for our clients. Social workers are social justice warriors, which means they must continue to support individuals who have experienced trauma. This study provides further investigation into the relationship of OCD and trauma, which in turn supports trauma survivors and the people who support them.

Understanding the connection between traumatic experiences of individuals and their symptoms assists clinicians in how they can better support their clients. This study could be valuable in informing the social work field and those working directly with trauma survivors. Additionally, it may help people heal on a deeper level.

Finally, this study sheds light on the effective treatments for persons who have trauma and OCD. Typically, OCD is treated with cognitive-behavioral therapy (CBT), but if an individual

also experienced trauma, that treatment may not be effective. CBT may be effective at reducing behavioral symptoms, but if the OCD emerged as a result of trauma, then the treatment may bypass the underlying causes of the symptoms. While there are current treatment modalities available, such as eye movement desensitization and reprocessing (EMDR) and sensorimotor psychotherapy (ST), this study illuminates other treatments that can be helpful when working with someone diagnosed with OCD and trauma.

Personal Motivation for this Study

Finally, I acknowledge my bias in researching this topic, as I identify as a trauma survivor. My personal experiences have informed, but not determined, my professional career. It is my deepest passion to create change and help others who have experienced trauma. Individuals who experience trauma have the right to competent care, and contributing to the body of trauma research is one way of supporting others and impacting the type of care they may receive. To counter any obstacles that may arise due to my personal bias, I consulted with my thesis advisor until the culmination of this thesis.

Conclusion

This chapter has presented an overview of the study, its pertinence and benefit to the field of social work and other mental health fields, and its relevance to trauma survivors themselves. My biases were highlighted, as well as the support I have received to limit the potential negative impact of these biases. The following chapter is the literature review that elaborates on the current research. The third chapter is the methodology, followed by a summary of the findings. Finally, Chapter V provides a discussion and analysis of the research.

CHAPTER II

Literature Review

The purpose of this study is to investigate clinicians' perspectives on the association between Obsessive Compulsive Disorder (OCD) and trauma in their adult clients and whether the symptoms of OCD bear meaning to the clients' experiences of trauma. In addition to exploring the definitions and empirical data surrounding OCD, this literature review will discuss theories that assist in conceptualizing these diagnoses and the experiences of persons diagnosed with these behavioral disorders. This chapter is divided into three sections. The first section discusses definitions of trauma and diagnoses, some of which are found in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) and the *Psychodynamic Diagnostic Manual* (*PDM*; Psychodynamic Diagnostic Manual [PDM] Task Force, 2006). It includes perspectives on the diagnoses of Post-Traumatic Stress Disorder (PTSD), OCD, and obsessive-compulsive personality disorder (OCPD), respectively. The second section discusses theoretical frameworks that explain the symbolic meaning of the symptoms of OCD and trauma. Finally, the last section presents empirical literature linking OCD and trauma and presents treatment options for those who have experienced these disorders.

Definitions

Trauma defined. Traumatic events are both individual and collective experiences, and there are similarities and differences based on how individuals react to the experience. Trauma is comprised of a myriad of experiences. Hatred and discrimination can result in trauma based on individual identities, which can include but are not limited to race, age, gender, sexual orientation, religion, ethnicity, nationality, class, and ability. The death of a loved one and the

witnessing of death have the ability to create an intense sense of traumatic grief. Interpersonal violence, assault, and historical, collective, and intergenerational trauma may span generations, transferred to children as well as groups of individuals. Perpetrating violence or any form of oppression has the capacity to be traumatic to an individual or a group of people. In other words, oppression can occur on a micro or macro level, and all oppression can be traumatizing (Basham, 2010; Herman, 1997).

Some of these traumas, such as political violence, terrorism, colonialism, natural or manmade disasters, xenophobia, combat, war, imprisonment, and displacement can be experienced on a national, system wide, and overt level. Navigating various systems holds the potential to be traumatic due to the perpetuation of oppression within systems. Despite the categorical descriptions, all traumas and forms of oppression have the capacity to be interlaced with one another and may become increasingly complex as individuals experience more trauma (van der Kolk, 2014).

Psychiatrist Lenore Terr conceptualized the range of traumatic responses into two levels (Basham, 2010). Type I comprises single, catastrophic events, such as natural and manmade disasters; deaths; loss of loved one, community, culture, and primary language; suicide; combat, accidents; medical diagnoses; and rape. According to Basham, “Type II trauma refers to the chronic repetitive abuses experienced by children” (p. 445) as they age. Type II trauma includes interpersonal violence and other forms or reoccurring maltreatment, such as microaggressions, and other traumas that are present through forms of oppression. Other theorists conceptualize Type III trauma as experiences of “violent torture” (p. 446), such as hostages in wartime.

DSM-5 definitions. A widely used publication in America, the *DSM-5* (APA, 2013) has created a foundation for researchers and clinicians to conceptualize behavioral ways of being.

The *DSM-5* considers the diagnostic criteria prevalence, comorbidity with other disorders, diagnostic features, functional consequences of disorders, suicide risk, identity related concerns to disorders, developmental considerations, and various risk factors. Below, I will be defining PTSD, OCD and OCPD from the *DSM-5* perspective.

PTSD. The principle criteria for all trauma- and stressor-related disorders in the *DSM-5* is that an individual must have experienced or been exposed to one “traumatic or stressful event listed explicitly as a diagnostic criterion” (APA, 2013, p. 265). Children under six only have to fulfill at least one criteria from the following categories to be diagnosed with PTSD: exposure to violence, intrusive symptoms, and avoidance or negative alterations in cognition, shifts in arousal levels, and the time span of the pain (APA, 2013). Individuals over the age of six require the same general criteria, however, more symptoms need to be present. Additionally, all trauma-related symptoms cannot be attributed to substance use. Both age groups require the specification of dissociative symptoms and delayed expression of symptoms.

The *DSM-5* (APA, 2013) finds that people who experience sexual violence, military combat, genocide, internment, and captivity are the most likely to experience PTSD. In America, “higher rates of PTSD have been reported among” (p. 276) individuals of color than white people, and individuals who are older are more likely to experience PTSD.

OCD. The *DSM-5* (APA, 2013) reports that about 1.2% of the American population is affected by OCD, and international rates are comparable. Men are not as likely to experience OCD, however they are “more commonly affected in childhood” (p. 239). As specified by the *DSM-5* (APA, 2013), obsessions and compulsions depict OCD: “obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in

response to an obsession...” (p. 235). OCD contains four main criteria: presence of compulsions and obsessions, whether the prior symptoms are time consuming or cause significant distress in critical areas of functioning, the symptoms are not attributed to a medical condition or substances, and the symptoms are not accounted for by another disorder. The specifiers assess the individual’s level of insight into how the disorder is impacting the person and whether the individual is currently experiencing, or previously has had, a history of a tic disorder.

OCPD. The vital characteristic of OCPD is a “preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness and efficiency. This pattern begins by early adulthood and is present in a variety of contexts” (APA, 2013, p. 679). The *DSM-5* necessitates four or more of the following symptoms present for a diagnosis: preoccupation with details to the extent that the essence of the activity is lost, perfectionism that interferes with completion of tasks, intense work production with the exclusion of pleasurable activities, inflexible to morality, unable to dispose of objects that do not carry a value, exhibits rigidity, desires for things to be completed in a particular manner, and stringent monetary use. OCPD is considered to be the most commonly diagnosed personality disorder; about “2.1% to 7.9%” (p. 681) of the clinical population experience it.

PDM definitions. The *PDM* considers a holistic framework in conceptualizing an individual’s level of functioning (PDM Task Force, 2006). This psychodynamic perspective considers “an individual’s full range of functioning” (p. 1), which includes various social, cognitive, and emotional patterns. Mental functioning, manifestation of symptoms, personality patterns, and individuals’ personal experience is explored in the *PDM*. The following reviews diagnostic criteria, patterns, and symptomatology and symbolism for PTSD, OCD and OCPD from the *PDM’s* perspective.

PTSD. Psychic trauma and posttraumatic disorders are considered to shatter “the foundations” (PDM Task Force, 2006, p. 100) of an individual’s life and to focus the individual’s attention to the past traumatic events. Trauma can create profound emotional dysregulation, a deep loss of security in the world, “fears of injury and death [and] intense apprehensions over the details associated with the trauma” (p. 101). Executive function, meaning making, and experiencing the self are deeply affected. Various relationships that the individual navigates may suffer due to attachment challenges. An individual’s body most likely somaticizes and remembers the trauma. Since memories of past traumas are circulated through the body and mind, individuals who have experienced trauma may become immobile from experiencing the present.

All responses to trauma can vary for individuals based on cumulative trauma, a single traumatic event, the nature of the trauma, and the individuals’ personal circumstances and resources available (PDM Task Force, 2006). Adults who experience trauma may exhibit the following features: fear, avoidance of trauma, “internal numbing,” “increased arousal” (p. 101), and intrusive re-experiencing of the trauma.

OCD. According to the *PDM* (PDM Task Force, 2006), “obsessive-compulsive disorders characterized by persistent intrusive thoughts (obsessions), and inflexible rituals (compulsions) may be understood as efforts to reduce severe anxiety” (p. 106). Not carrying out the obsessions and compulsions lays a bedrock of deep, unconscious fear of “potential loss of control” (p. 106). The obsessions and compulsions are considered to be “crimes” that haunt individuals through “obsessive images and ideas” (p. 106). To make amends, rituals are performed. Children around the ages of six to nine may form benign rituals, which may indicate a need to potentially control

their future. Exploring potential stressors, losses, and recent changes may shed light onto the individual's distancing from the loss of control observed in OCD.

OCPD. In similar fashion to the *PDM's* conceptualization of OCD, people who experience OCPD are considered to keep emotions at a distance, due to the intense feelings of not desiring to feel “out of control” (PDM Task Force, p. 58). Many who are diagnosed with OCPD may have experienced “dyadic struggles” (p. 58) during their childhood. Living with a controlling parental figure may have sparked the obsessions and compulsions for individuals with OCPD. “Caregivers who expected [their children] to be more grown up than was possible at the time” (p. 58) may contribute to their children's diminished self-esteem, which may perpetuate the concept that they acted immaturely.

Individuals who experience OCPD are very likely to be incredibly self-critical, perfectionistic, and are afraid that their compulsions and obsessions will become an unstoppable reality (PDM Task Force, 2006). Unless it is “logically or morally ‘justified’” (p. 58), persons who experience OCPD struggle to accept their emotions. Decision-making is a challenge since many of these compulsions and obsessions require extensive attention to detail and much mental energy, because the thoughts are “chronically ‘in their head’” (p. 58). This can also be seen as the “doubting mania” (McWilliams, 2011, p. 300), because decision-making can create a state of paralysis for the individual who wants to please all external parties.

It is important to note that understanding the internal experience of someone diagnosed with OCPD may resemble other personality disorders, because of the similar compulsive and obsessive characteristics (PDM Task Force, 2006). Prior to diagnosis, understanding the role that the obsessions and compulsions hold for the individual must be accounted for; the internal experiences of the individual are critical. The *PDM* (2006) considers there to be two subtypes of

OCPD: obsessive and compulsive. For individuals who experience obsessions, their self-esteem may be influenced by their ruminative thinking patterns and intellectual accomplishments.

Individuals who experience compulsions may exhibit perfectionistic tendencies, and their self-esteem relies on completing various achievements.

Theoretical Explanations of Symptoms and Symbolism

Posttraumatic disorders. As previously mentioned, trauma encompasses a vast range of experiences and social locations. Psychiatrist Bessel van der Kolk (2014) defines trauma as “unbearable and intolerable” (p. 1) experiences that engender past traumatic memories into an individual’s present through physical and emotional sensations. Those emotional and physical experiences are representations of how the trauma has manifested itself in the individuals’ body and mind. According to van der Kolk, individuals who experience trauma may struggle in tolerating their affect, connecting to others, feeling pleasure in daily occurrences, and feeling fully engaged in the present.

Judith Herman (1997), a psychiatrist, theorizes that “the ordinary response to atrocities is to banish them from consciousness” (p. 1). An individual’s sense of connection and meaning of control of oneself are clobbered by these painful and overwhelming traumatic events. Herman believes that traumatic experiences instill feelings of helplessness and terror in the individual who survived the trauma. Because of the traumatic events(s) an individual may experience, a person may experience a state of heightened alert, intrusive reminders of the trauma(s), emotional dysregulation, dissociation, and loss of connection to what was once captivating.

Social Worker Maria Yellow Horse Brave Heart (2011) coined the term historical trauma, based on her extensive research on Native American individuals and communities who survived genocide and historical trauma. Brave Heart defines historical trauma as the

“cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma” (Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283). Consequently, unresolved grief persists through the Native American communities and other groups of people who have collectively experienced trauma or oppressive barriers. Brave Heart and her colleagues (2011) state that historical trauma continues to exist for Indigenous individuals, because they have not had the opportunity to heal collectively through combatting stigma and isolation and leaning upon their traditional healing methods.

Traumatic events have been common experiences for individuals and communities since the beginning of time. “Denial of both the enormity and reality of traumatic events further distorts our understanding of trauma” (Basham, 2010, p. 440). Numerous theorists, such as Sigmund Freud, originated their work regarding trauma in the interpersonal violent family dynamics that an individual may experience. In America, it was not until the culmination of World War II that the American Psychological Association included PTSD in the *DSM-III* (1980). PTSD and trauma were originally seen as a soldiers’ concern; this excluded marginalized populations, such as people of color, women, and people who identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ). Uproar from various groups of people “heightened public awareness of trauma” (Basham, p. 443) and assisted in dismantling myths surrounding it. Denial continues to perform a detrimental force in combating and healing trauma on an individual and macro level.

Traumatic events and responses are distinct; events are occurrences that are severe and pose a threat to an individual’s wellbeing. All neurobiological responses to trauma are universal. During the traumatic event or a memory of it, the body may react in various ways: a racing heart, increase in blood pressure, and perspiration (Basham, 2010). Individuals experiencing a

traumatic event may find themselves numb and or stimulated emotionally. Nevertheless, individual responses are unique and culturally directed. In more Westernized cultures, individuals may react in a flight, fight, freeze, and submit response while others may “pause-collect” (p. 453). This tactic is a method of reaching out to others from whom an individual received support.

A segment of the individuals who experience trauma will respond with short-term struggles, but others may respond with long-term stress. Depending on multiple factors, an individual’s response to trauma will differ greatly based on the person’s level of resiliency. Resiliency is based on the age of when a traumatic event occurred and several protective factors. An individual’s support system, prior knowledge/ education surrounding traumatic events, supportive relationships and community, sociocultural factors and levels of personal “hardiness” (Basham, 2010, p. 449) can serve as protective factors. Hardiness is “defined as a positive, optimistic outlook, a belief in the purposefulness of one’s actions... and an outlook toward the future” (p. 449). Other factors that may “determine the likelihood that an individual will develop post-traumatic stress disorder following” (p. 450) trauma are relationship with the perpetrator, duration of abuse, a general sense of “unpredictability and uncontrollability” (p. 50), and the intensity the experience.

Traumatic experiences can “severely disrupt children’s emotional, social, language, and intellectual development” (PDM Task Force, 2006, p. 336). The body reflects the traumatic experiencing, regardless of age, through biological disruptions, or somatic states, which may look like chronic pain, an increased heart rate, and sweating, among other symptoms. Relationships that the individual has may be affected by the trauma. An individual who has experienced trauma has an increased likelihood of experiencing emotional dysregulation,

concentration, hypervigilance, nightmares, all or nothing thinking, and preoccupation with the trauma and other perseverating thoughts, all of which may be rooted in deep seated, concrete fear. The development of anxiety, dissociation, eating disorders may arise. Many of these symptoms may be related to obsessive and compulsive thought processes. “Children who are able to play symbolically may reenact” (PDM Task Force, 2006, p. 337) aspects of the trauma. Obsessive and compulsive behaviors may emerge as a tactic, in an attempt of managing the anxiety. Whether an individual directly or indirectly experiences trauma, anxiety symptoms may emerge and even assist in traversing through the trauma.

Situated on the spectrum of stress, trauma is an excruciating form. However, trauma is regarded differently, depending on the theorist. Freud believed that hysteria developed as a consequence of “internal intrapsychic conflicts between traumatic events” (Basham, 2010, p. 441) that remained conscious, yet not integrated in the individuals’ present experience. Basham interprets Figleys’ conceptualization of trauma as an “emotional state of discomfort and stress resulting from the memories of an extraordinary catastrophic experience” (p. 443), and that can make someone more vulnerable to experiencing trauma.

According to the PDM, “adolescent females are more vulnerable to posttraumatic stress syndromes, while adolescent males are more disabled by their regressive responses to trauma” (PDM Task Force, 2006, p. 260). However, the younger the individual is, the more visible the symptoms are.

OCD. Overall, symptoms of OCD wax and wane throughout an individual’s lifetime; however, there are definite ages where an onset of OCD more commonly occurs (PDM Task Force, 2006). Children as young as 4 can experience OCD, but typically, children around the ages of 6 to 9 and the middle range of adolescence experience an onset of OCD. Additionally, if

a prior onset has not materialized, young adulthood is considered to be the final age range for OCD to develop. Regardless of age, the onset of OCD may spawn as a result of increased stress, particularly if the primary caregivers did not assist the child in reducing and managing those stressors, but instead magnified the stress.

The symptoms of OCD may communicate unconscious and or conscious anxieties (PDM Task Force, 2006) and inhabit an unwanted, disturbing presence for the individual (McWilliams, 2011). Fantasies and thoughts may involve rumination of specific ideas or actions, and the rituals associated with those may act as defense mechanisms. Somatic symptoms that develop may be related to the individuals' anxieties and phobias and an increased preoccupation of health concerns.

Rachman (1994) theorized that individuals who experience psychological and other forms of trauma at a young age and who develop OCD may experience "mental pollution" (p. 311). A sense of feeling "dirty from within" (Gershuny, 2003, p. 1039) may have originated as a result of trauma, and/ or literal dirt in their external environment that was "observable dirt" (Rachman, 1994, p. 311). This deep seated fear of contamination was defined by Rachman (2004) as: "an intense and persisting feeling of having been polluted or infected or endangered as a result of contact, direct or indirect, with a person/place/object that is perceived to be soiled, impure, infectious or harmful" (p. 1229). As a result of experiencing and internalizing external forms of dirtiness, coping strategies emerge as OCD symptoms, which are attempts at controlling their environment and themselves. (Rachman, 1994, 2004). The concept of internal dirtiness has been linked empirically to traumatic experiences. The majority of Rachmans' studies focused on the physical symptoms of OCD (2004). However, he proposed that the mental pollution (1994), the OCD symptoms, can directly reflect the traumas one experiences. For example, in one of his

studies (2004), he noted that over half of the women had the need to excessively wash their genitals, experienced intrusive thoughts, and extended their shower times. Those experiences, he stated, mirrored their sense of “internal dirtiness.” Multiple theoretical frameworks were seen to be supportive for clients who experience OCD, and internal “mental pollution” (Cogle, Lee, Horowitz, Wolitzky-Taylor, & Telch, 2008, p. 351).

Researchers de Silva and Marks (1999) found that there was a certain level of vulnerability in the individuals who experienced symptoms of OCD after a traumatic event. It was also noted that these individuals as children were given an excessive sense of responsibility, potentially far beyond their maturity (Salkovskis, Sharean, Rachman, & Freeston, 1999). It was theorized that those children must have had to adhere to ridged rules, and this rigidity could have set the stage for experiencing trauma and OCD (Salkovskis et al., 1999). These researchers suggested that both the OCD and the trauma must be treated for someone to completely heal.

OCPD. Much like OCD, the symptoms of OCPD are symbolic of conscious and unconscious anxieties, aggression, and avenues of control for children and adolescents (PDM Task Force, 2006). As reported by the *PDM* (2006), many clinicians in Western cultures “believe that the neurotic level syndrome of obsessive-compulsive personality disorder is becoming more subtle or rarer” (p. 57), potentially due to the decrease in experiencing authoritarian parenting. “Children and adolescents with obsessive and compulsive personalities are preoccupied with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness and efficiency” (p. 221). All compulsions and obsessions lay on a spectrum of symptoms that present as more severe or benign. To hold anxiety at bay, the primary defense mechanisms that may emerge for obsessive individuals are intellectualization, compartmentalization, and affect isolation. Comparatively, “compulsive children handle anxiety

with repetitive perfectionist behavior that may have the meaning of ‘undoing’ their fantasied badness” (p. 221).

In Western societies, where production is highly valued, individuals with action and thinking oriented personalities are valued and commonplace (McWilliams, 2011). Unlike an individual who experiences OCD, an individual who experiences OCPD may view their compulsions and obsessions as ego syntonic (McWilliams, 2011). For an individual whose obsessions and compulsions are recognized as ego syntonic, those symptoms are regarded as congruent and beneficial to that individuals’ functioning.

Individuals who experience obsessions and compulsions may “use words to conceal feelings, not express them” (McWilliams, 2011, p. 293). That individual may struggle to connect their internal experience to an external incident. According to McWilliams (2011), Sigmund Freud theorized that individuals “who develop obsessive-compulsive disorders were rectally hypersensitive in infancy, physiologically and constitutionally” (p. 291). The primary defensive mechanisms that may be utilized by compulsive individuals is undoing. Individuals who have obsessive tendencies may deploy the following defense mechanisms: intellectualization, displacement, compartmentalization, and moralization. People who experience both obsessions and compulsions may isolate as well.

Empirical Research

The link between OCD and trauma. While there is not an extensive amount of literature pertaining to the relationship between trauma and OCD, several researchers across the world have explored this distinct relationship. A study in Israel specifically explored this relationship between childhood sexual abuse and OCD and found that there was a positive correlation between childhood abuse and OCD (Caspi et al., 2008). Another study, which was

completed in China, specifically examined childhood trauma and how it can impact symptoms of OCD (Wang, Wang, Xu, Zhang & Xiao, 2011). The researchers found that over 75% of the participants who were diagnosed with OCD experienced trauma in their childhood (Wang et al., 2011). Males who were diagnosed with OCD were more likely to experience physical and emotional abuse while their female counterparts were more likely to experience sexual abuse (2011). A study that was completed in 2010 found that children and adolescents who experienced OCD were much more likely to have experienced psychological trauma as younger children than those who did not (Lafleur et al., 2010). It was also noted that soldiers who came back from war were much more likely to be diagnosed OCD after experiencing the traumas that may have occurred during their time in combat and in the military (Pitman, 1993).

Several researchers have investigated the connection between OCD and traumatic experiences through case studies. Each case study found that OCD developed after a traumatic experience, and compounded traumas furthered the development of OCD (de Silva & Marks, 1999). The individuals that were discussed developed OCD within weeks of the traumatic experience (de Silva & Marks, 2001). The symptoms of the OCD each person experienced were salient to that person's trauma. However, there was no discussion that OCD symptoms carried any significance in regards to the trauma that the individuals experienced (de Silva & Marks, 1999). Intrusive thoughts, compulsions, and obsessions were the main symptoms that emerged as a result of the traumatic experiences, but these can also be perceived as symptoms of trauma instead of solely OCD (1999). The emergence of OCD in someone who has experienced trauma may act as a coping mechanism to keep the traumatic experiences suppressed (Gershuny, Baer, Radomsky, Wilson, & Jenike, 2003).

Hoarding has been shown to have a strong correlation to traumatic experiences. Research suggests that traumatic experiences are considered to be potential catalysts for the onset of OCD and, more specifically, hoarding (Cromer, Schmidt, & Murphy, 2007). Shifts in relationships and intimate partner violence have been found to illustrate a connection to the onset of hoarding (Tolin, Meunier, Frost, & Steketee, 2010). Various traumatic experiences such as deaths and displacement were also considered to influence hoarding symptoms (Tolin et al., 2010). Another set of researchers found that individuals who experience rape, sexual assault, and abuse were more likely to develop OCD and, more specifically, symptoms of hoarding (Przeworski, Cain, & Dunbeck, 2014).

The reviewed literature revealed that there is a correlation between OCD and trauma, but there are few studies regarding the potential meanings behind those OCD symptoms. There may be meaning behind each symptom of OCD, which could suggest the need for a more intensive treatment option, rather than just an elimination of the presenting symptoms. All the data presented substantial support for a connection between OCD and traumatic experiences. Several researchers (de Silva & Marks, 2001) recommended screening for trauma when working with an individual who is presenting with symptoms similar to OCD. Other researchers recommended that clinicians treat OCD and PTSD simultaneously (Salkovskis et al., 1999). Overall, there is a gap in the literature exploring the relationship between OCD symptoms and past traumatic events and an omission of effective treatment modalities when both diagnoses and experiences are present for an individual.

Treatment options. When contemplating treatment options for OCD and traumatic experiences, it is important to be mindful of the various modalities available. A spectrum of psychodynamic therapy and cognitive behavioral therapies are considered, along with

nontraditional Western therapies and healing techniques. “Establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community” (Herman, 1997, p. 3) are the critical initial steps in the healing process regardless of the treatment. The following is a summary of the treatment options for OCD and trauma.

Psychodynamic therapy. Psychodynamic therapy is considered effective for individuals who have experienced trauma and have been diagnosed with PTSD. Incorporating a strength-based perspective, psychodynamic treatment of trauma places emphasis on the therapeutic alliance, transference, and countertransference of the therapeutic interactions (Moss, 2009). The individual’s past relationships are discussed to tap into potential patterns and origins of behaviors and feelings. In addition to creating a nonjudgmental, holding environment for the client, an exploration of the client’s conscious and unconscious behaviors, feelings and thoughts, and mindfulness practice is critical to healing. Psychodynamic therapy does not place an exclusive importance to symptom management, but understands client wellbeing and healing signifies an individual’s sense of passion and vitality.

There is an absence of studies supporting psychodynamic treatment for individuals with OCD, but utilizing a psychodynamic approach is certainly appropriate for all individuals seeking support (Greist & Jefferson, 2014). Specifically, creating a therapeutic alliance, establishing safety, expressing empathy, focusing on the individual’s strengths, and providing a holding space for the client’s affect is essential for effective treatment, and these psychodynamic techniques can be integrated into other treatment modalities.

Cognitive behavior therapy (CBT). Considered the primary and sole treatment for individuals who experience OCD, CBT aims to change the clients’ thoughts, behaviors, and feelings in order to decrease relevant symptoms (Greist & Jefferson, 2014). For treatment to be

considered effective, ritual prevention and exposure to the individuals' triggers, which stimulate their obsessions and compulsions, are utilized. Exposures are utilized to desensitize an individual to their triggers, which in turn decreases levels of distress surrounding the triggers. Anxiety increasing during treatment, especially when exposures are employed, is expected. Ritual prevention is designed to reduce the urge to perform rituals. Rituals are intentional behaviors that briefly decrease anxiety for an individual, but over time increases the likelihood the ritual will be performed.

Psychoeducation is utilized in treatment to strengthen the clients understanding of their diagnosis. Clients are given homework assignments so they continue to practice the skills they are taught in therapy. Many studies have shown that CBT is an effective treatment for individuals experiencing OCD. Approximately 64% of individuals who participated in various studies reported an increase in symptom reduction after completing 12 hours of exposure and ritual prevention work (Greist & Jefferson, 2014).

A type of CBT, cognitive processing therapy (CPT) emphasizes changing the maladaptive thoughts or cognitions regarding the trauma (Youngner, Rothbaum, & Friedman, 2014). There are three principle protocol phases that intend to target the way in which the individual thinks about the traumatic event. Psychoeducation surrounding trauma and PTSD, along with the identification of the unhelpful beliefs regarding the trauma, are initially discussed. To challenge these beliefs, the individual is instructed to formulate a written exposure of their trauma. Evidence supports CPT as an effective treatment for PTSD as it has reduced PTSD symptoms (Youngner et al., 2014).

As previously discussed, CBT intends to shift an individuals' behavior, thoughts and feelings to decrease related symptoms. Prolonged exposure therapy (PE) is based on the

reduction avoidance conditioning that may arise from traumatic experiences by exposure and conditioning methods (Youngner et al., 2014). The repeated exposure to the individuals identified trauma aims to reduce a higher state of arousal, and decrease related symptoms, although symptoms can increase during treatment. Breathing techniques are also utilized to strengthen the likelihood of a successful treatment (Youngner et al., 2014). Psychoeducation regarding PTSD symptoms is recommended during treatment, so that the client may become increasingly aware of how their diagnosis may affect their functioning. Although PE is considered to be an effective treatment, improvement of symptoms reduction was no different than the other CBT methods (Youngner et al., 2014). “Exposure [therapy] sometimes helps to deal with fear and anxiety, but it has not been proved to help with guilt or other complex emotions (van der Kolk, 2014, p. 223).

CBT has been greatly studied in the treatment of PTSD and other traumatic experiences. However, CBT treatments have not proven to be affective in the healing process for individuals who experienced child abuse (van der Kolk, 2014). At most, a third of individuals who receive in CBT treatment notice a reduction in symptoms, but continue to experience the effects of their traumatic experiences which may be reflected in their mental and physical well-being (van der Kolk, 2014). CBT can be a beneficial supportive therapy, not the primary venue (van der Kolk, 2014).

Eye movement and desensitization reprocessing therapy. This psychotherapy modality was designed to decrease the emotional and physical distress levels of trauma and heal individuals from their related traumatic experiences (Youngner et al., 2014). EMDR therapy consists of eight treatment phases that focus on distressing event, identified by the client. The treatment combines trauma-exposure along with bilateral stimulation of the body (tapping of the

body and particular eye movements). Coping skills are explored for the client to lean upon in the likelihood there is an increase in symptoms. A multitude of studies illustrate this treatments' efficacy in treating PTSD and other trauma related disorders and experiences. Many EMDR therapy participants reported a significant decrease in PTSD related symptoms after at least six sessions (Youngner et al., 2014).

Sensorimotor psychotherapy (SI). Developed by psychotherapist Pat Ogden, SI is a somatic therapy that pulls from psychodynamic therapy and CBT to treat unresolved trauma (Ogden, Minton & Pain, 2006). Traditional treatment modalities, such as talk therapy (CBT and psychodynamic therapy), may not have the complete capacity to treat the trauma because traumatic memories are stored in the body. Throughout SI treatment, the therapist supports the client in navigating the traumatic events by focusing on physical sensations related to the traumatic memories and verbalizing them. At times re-experiencing the event during treatment is executed through physical movement. Experiencing SI encourages self-awareness of emotional and physical sensations and helps reduce the overall traumatic responses (Ogden et al., 2006). While it has not been as widely studied as other treatment modalities, SI is an effective treatment for PTSD (van der Kolk, 2014). Because trauma is stored in the body, this approach purposefully utilizes that body's memory to heal the trauma on a level where talk therapy cannot reach.

Body oriented work. It can become quite challenging for an individual who experienced trauma to feel fully present and safe in their bodies. Verbalizing and writing out an individual's traumatic experiences can be a healing practice because language is a powerful tool for self-expression and regaining connection (van der Kolk, 2014). van der Kolk reports that dance, art, and music have been shown to be effective and evidence based healing experiences and modalities.

Sociologist, yoga instructor, and activist, Thompson (2014) believes that yoga can heal a myriad of traumatic experiences. Thompson identifies as a trauma survivor has found that in her personal and professional yoga practice, trauma resides in the body. Yoga assists in cultivating a sense of safety in an individual's body and an increased connection to the body. This form of exercise reportedly supports an increased sense of self-awareness, emotional and self-regulation, and connection to the world (Thompson, 2014).

Conclusion

Collectively, this literature review discussed the definitions of trauma and OCD, explored nontraditional and traditional treatment options, current literature, and the theoretical explanations of symptomatology and symbolism. Considering the strengths and limitations of the current research, there is a need for a study that investigates the relationship between OCD and trauma, specifically support for individuals experiencing OCD and trauma and the meaning behind particular symptoms. The intention behind my study is not only to explore the relationship between OCD and trauma in adults, but also to investigate the potential significance behind OCD symptoms and traumatic experiences. My research study will fill the gap in the literature but also present clinicians' perspectives and clinical work on the topic. The third chapter will outline the methodology that is utilized in my study. A discussion of the research design and sample will be followed by data collection section and data analysis. Ethical concerns, validity, and reliability will conclude the next chapter.

CHAPTER III

Methodology

This study is focused on the following research question: *What are clinicians' perspectives on the association between OCD and trauma in their treatment of adult clients, and how do the symptoms of OCD and trauma reflect the traumatic experiences?* The purpose of this thesis is to explore clinician's perspectives on the connection between traumatic experiences and obsessive-compulsive disorder (OCD) in adult clients and whether the symptoms of OCD reflect the traumatic experiences. The most appropriate design for this question was a qualitative methodology. Semi-structured open-ended questions were utilized in the interviews to encourage personalized responses from the clinicians and their experiences in the field. The study aims to further the investigation and increase understanding of the connection between symptoms of OCD and trauma. Few studies regarding this connection have explored the potential meaning behind an individual's OCD symptoms and a traumatic past.

Research Design

A qualitative method for my study was the optimal selection because it provided an open, yet guided space for the participants to share their understanding of their clients who experience trauma and OCD. The semi-structured interview questions were designed to keep the exchange running smoothly while covering important discussion points. Unlike a quantitative study, a qualitative study seeks to investigate the nuances of an experience through verbal interactions and questions that explore the significance of studied experiences (Engel & Schutt, 2013). The

purpose of my study was to further understand the subjectivity of the relationship between traumatic experiences and OCD symptomatology and the potential significance behind these. Lived experiences are invaluable to my study, and I would not be able to obtain the depth of information if I had selected a quantitative method.

Content analysis grounded my data collection and analysis method. This technique was selected primarily because it allowed for an exploration of the latent and explicit language in the interviews as well as an investigation into the relationship between the spoken words. Coding was used to categorize the various themes that were revealed in the data.

Ethical Considerations

Prior to data collection, this study was approved by the Smith College School for Social Work Human Subject Review Committee (SCSSW HSR) (See Appendix A). As I produced my thesis, I continually evaluated how I maintained ethical standards. Location of the interviews were carefully considered to ensure privacy of the participants and the clients they presented. I sent a copy of a consent form (See Appendix B) to each participant, and I had participants sign a copy that I filed away in a locked cabinet. Prior to the commencement of the interviews I stated that the clinicians omit any identifiable information regarding their case presentations. Once the interviews ended, I asked the participants if any identifiable client information emerged. If any did emerge, the identifying information was deleted from the transcripts and omitted from the write-ups. All consent forms and other paperwork was stored in a locked file. Computer files were secured on a password protected computer.

Sample

The participants were trauma-informed clinicians (social workers, psychologists, or other licensed mental health counselors) who have practiced for a minimum of 1-2 years. These

individuals were gathered through snowball sampling; I reached out to the Smith College School for Social Work students, graduates, other clinicians on Facebook and LinkedIn, and clinicians at various domestic violence shelters where I have worked in the past. These individuals were trauma-informed or at least supported a client who had experienced trauma. As I reached out to various organizations and individuals, I specified that I could not interview those with whom I was acquainted. While I proposed to interview a minimum of 12-15 participants, I obtained nine clinicians for the study.

My recruitment period lasted for three months (February- May 2017) and during that time, I reached out to numerous individuals on Facebook, LinkedIn, and through email. In an attempt to increase the sample size, I altered the participation requirements twice. Those changes were reflected in the HSR criteria, as well as the recruitment letters. On March 2, 2017 the first of three Research Protocol Change Forms was approved by Smith College School for Social Work HSR. In this form, I requested that the sample size expand from Massachusetts to the rest of the country, include clinicians who are licensed not just independently licensed, and add video chat as an option to an in-person interview. The second form, which was approved on March 29, 2017 detailed my request to decrease the minimum of years of experience from 3-5 years to 1-2 years, and utilize the following language: instead of clinical examples that include clients with diagnoses of OCD/OCPD, to include individuals who exhibit obsessive/compulsive traits/behaviors. My final form, which was approved on April 10, 2017, requested the need for additional transcribers. In addition to after each form approval, I sent out my recruitment letters through social media each week. Various individuals shared my study with others and each person who reached out to me, I followed up with through email and a telephone conversation. See Appendix A for all approval forms.

Data Collection

Data for this study was collected between February 2017- May 2017. Two recruitment letters (Appendix C) were sent out through social media (Facebook, LinkedIn and email) to various clinicians in Massachusetts. Interested clinicians were encouraged to contact me through my cell phone and school email. After contacting the interested participants, I screened them for eligibility. Once they were screened and decidedly eligible, I asked if the participants could provide me with their mailing address to send them a copy of the consent form. Once the interested participant received the consent form, I requested that they call me to set up a time and place for the interview. The recruited clinicians were from differing backgrounds, regarding gender, ethnicity, race, class, age and field experience (see Chapter IV for demographics). Once data was collected, one participant was randomly selected to receive a \$25 gift card to Target. I notified this individual by email, then emailed them the gift card.

Semi-structured, open-ended questions were used to guide the 45-60 minute interviews with the participants (see Appendix D for the interview guide). When necessary, I utilized more structured questions to ensure that each question was answered. Each interview was conducted in a private location of the interviewee's choice. All the interviews were audio taped with my cell phone and an audio recorder. After I confirmed that that the machine recorded the interview, the recording on my cell phone was deleted to maintain privacy.

Data Analysis

After the respective interviews were completed, I, as well as two additional individuals, transcribed the data verbatim and imported the transcripts into a qualitative analytic computer program called *Atlas.ti*. This program assisted me in locating, coding, marking up the significant

findings in the data. Salient quotes were extracted from the transcriptions, and the various patterns were organized and examined for their significance.

To analyze the data I acquired from the interviews, I grounded my investigation in content analysis and narrative. This method of analysis appropriately fits the purpose of the study because it interprets the participants' responses for deeper meanings as it considers the "explicit and implicit" text (Steinberg, 2015, p. 116). Coding guidelines were created, with the assistance of my thesis advisor, to identify patterns that emerged from specific words and concepts found in the interviews.

Rigor and Trustworthiness

Throughout the composition of my thesis, I received guidance from my thesis advisor and colleagues to ensure that the reflection of the data was accurate. In a balanced method, the participants were represented in the findings through direct quotes from each participant, accurate transcriptions of all interviews, rigorous record keeping, and maintaining confidentiality. Finally, I have continually assessed and acknowledged my biases that could have affected the study findings.

Reflexivity was a continuous consideration as I completed my thesis, because I identify as a trauma survivor. As previously mentioned, my past does not dictate my future decisions, but it certainly has been an influential factor. My past experiences ignited my passion to create change and support others who experience catastrophic traumatic pain. While my bias may bring to light potential limitations, I believe that my past informs my clinical and macro social work practice. Contributing to the body of literature of traumatic studies allows me to give back to others who experienced intolerable and disastrous events. My biases are stepping stones from

which I can acutely view the world and create change. Nevertheless, as a social worker, it is essential to continue to evaluate the work I undertake.

As someone who is attuned to traumatic experiences due to my own history of trauma, I was thoughtful and critical of the way I utilized my experiences and identities as I wrote my interview questions, my presentation during the interviews, and how I interpreted the findings. After each interview, I noted my thoughts of the interaction, and reflected upon my potential biases. Throughout the process and until the completion of my thesis, I continuously consulted with my thesis advisor to thwart concerns as they arose.

Conclusion

Chapter III discussed the methods in which my research question was explored. Ethical considerations were examined and rigor and trustworthiness were explored as my biases inform my clinical and macro social work practice. The design of my study was stated, as well as the manner in which the data was collected and analyzed. The following chapter will dive into the findings of my research.

CHAPTER IV

Findings

The intention of this study is to explore clinicians' perceptions on the relationship between OCD/OCPD and traumatic experiences in adult clients and whether the emergence of OCD/OCPD symptoms bear meaning to their trauma(s). This chapter contains the findings that are based on nine interviews conducted with professionals from varying mental health fields (social work, nurse-psychotherapy, and psychology). Interviews were conducted through video chat and in person meetings, transcribed by myself, and two additional transcribers, and then were fully coded using a blend of content analysis and narrative analysis.

The overall research question was: *What are clinicians' perspectives on the association between OCD and trauma in the treatment of adult clients, and how do the symptoms of OCD and trauma reflect the traumatic experiences?* To explore this question, the semi-structured interviews consisted of four defined sections: 1) demographic data about the participants' clinical and educational experience, and the primary theoretical frameworks utilized; 2) questions about participants' clinical work with trauma, training, conceptualization, and best practices; 3) questions about participants' clinical work with OCD/OCPD, training, conceptualization, and best practices; and 4) examples of clinical cases (clients who experienced trauma and presented with obsessional/ compulsive traits and behaviors) that were presented by participants (which included the types of traumas the clients experienced, formal diagnoses made, and other

pertinent information), as well as a discussion around treatment modalities and recommendations. Major themes that emerged from the results will be discussed.

Demographic Data

Three cisgender females and six cisgender males comprised the study. The interviewees' race was not asked in the demographic section of the interview, and no one self-identified their race. All participants were above the age of 18. Seven of the interviewees received their master's in social work, one was a medical psychologist, and another was a nurse psychotherapist with a bachelor's in nursing and a master's in psychology mental health nursing. One of the social workers had previously received a master's degree in education, another received a graduate degree in "organized outdoor experiences," and another received a degree in theology prior to receiving his master's in social work. Four out of the nine interviewees graduated from Smith College School for Social Work. The rest received their clinical graduate degrees from Boston University, Stony Brook on Long Island, Baylor University, University of Kansas, and George Wanes College. The social worker who received her master's in education studied at Marquette University. Over half (six) of the participants graduated from their graduate programs within the last decade.

Past and current work settings varied greatly among the participants. Three participants presently work at a Veterans Affairs Hospital in the mental health outpatient clinic. Two of the social workers were deeply involved in the batterer prevention and intervention field, and domestic violence field. One of the social workers primarily worked in macro level social work, while the rest of the individuals primarily focused on clinical work. Other work settings included private practice, college counseling, residential programs, inpatient programs, an OCD mental

health outpatient clinic, specific programs for traumatized children, and a domestic violence shelter.

Major Themes

Throughout these interviews, four major themes surfaced: 1) all clinical case examples revealed traumatic histories, most stemming back to childhood; 2) obsessional/compulsive traits/behaviors manifested themselves in the clinical case examples as ways of managing internal and external stress and anxiety; 3) there were mixed treatment considerations and recommendations among the mental health professionals; and 4) significantly more cisgender males than cisgender females were presented in the clinical material. The following sections detail each major theme, and letters rather than names identify participants, in order to maintain anonymity.

Commonalities between clinical cases: Traumatic histories. As a participation requirement, interviewees must have worked with at least one adult client who had a history of trauma and obsessive/compulsive traits/behaviors. Seven out of the nine interviewees (P-B, P-C, P-D, P-E, P-F, P-G, and P-H) reported that their clients with OCD symptoms or traits experienced childhood abuse, and all participants stated that the clients experienced traumas as adults as well. The types of childhood abused detailed by the interviewees included religious abuse, sexual abuse, physical abuse, emotional abuse, combat, and emotional neglect. Participant F expressed that he understood his clients' trauma as "threefold:"

The earliest was the trauma in the home of the father being abusive, being volatile, and threatening. The second is the traumatic loss of the father and the longing for his father was never met... And third... trauma of being a gay child in an evangelical Christian

household, where he heard homosexuals were the work of the devil and damned... it placed him in an unspeakable dilemma.

Participant F was not the only interviewee who described traumatic relationships between his client and a religious institution.

In another interview, Participant B presented two clients, both of whom experienced childhood trauma. One of the clients he discussed was about a woman who lived in rural Mexico as a child. Around the age of 8, she attended a party at her Catholic church and “during the celebration, this boy took her aside... and sexually molested her. So, she went to the priest, and she told the priest what she had experienced, and then the priest proceeded to sexually molest her.” The participant continued by stating that “she had tried to tell her parents, but she was 1 of 12 children and she was kind of 3 quarters of the way down.” As a result, “her mom wouldn’t listen to her, her father wouldn’t listen to her, and so she just kind of sat on it.”

Participant B’s first client “had quite an extensive trauma history witnessing domestic violence throughout his childhood.” The client was also physically abused by his older brother and eventually began “beating up” his peers. Participant B conducted the clients’ intake at a batterer intervention program after the client was arrested for physically abusing his girlfriend.

Participant H originally met with a client because of his presenting OCD symptoms. A year after he ended treatment with her, he resumed and disclosed that he had experienced, in the participant’s words, “incestuous sexual abuse in childhood.” Participant C discussed a client who faced military sexual trauma, emotionally and physically abusive work environments, and an abusive childhood. The interviewee stated that his clients’ “father was physically abusive to him, I think he generally hit him in the obedience kind of way. Also he was thrown down the basement stairs by dad; he got a concussion there.” The participant added: “I think his mother

lied to the doctor. His skull got broken, he had to have stiches, his dad either pushed him into the sliding door and he went backwards.”

While Participant G discussed two cisgender male clients, both veterans, who are currently attending one of the batterers’ intervention groups he conducts, he spoke in depth about one of them. In addition to the combat trauma, the client experienced relational trauma: he had a “very chaotic and abusive childhood.” The interviewee stated that the clients’ mother was addicted to drugs and “had multiple boyfriends,” and as a result, the client “was essentially left alone, he grew up isolated.” One significant relationship that the client had as a child was with a homeless man that parked the car in his mothers’ driveway, and lived there for several months. “This man had given him more attention than anyone else in his life.”

One of Participant E’s clients was someone with intellectual disability and OCD. When he was first found, “he was living in filth, including his own filth. Sexually abused, physically abused, and probably, there are indications of traumatic brain injury at the hands of caregivers.” The second client she (P-E) discussed, “has been on the run for the majority of his life. We’re the first place where he’s stayed and not run away from.” While the details of his trauma were not discussed, being “on the run” for the larger part of one’s life can be considered traumatic.

Participant D presented on a “Navy combat engineer” who survived combat as well as a difficult childhood. The client “talked about having a childhood where he felt that the rug would always be pulled under him. Like a childhood that was very chaotic, not knowing how his parents would react to him, always having to be on his toes.” Despite Participant D not discussing the details of the client’s past during the interview, he considered it traumatic.

Unlike the rest of the interviewees, Participant A and Participant I did not share whether their clients experienced trauma as children. Participant A only stated that the client experienced

combat trauma once he was enlisted in the military. “He was a correctional officer. When he was on base, he was fired at, he also watched inmates, made sure nothing was going on.” In my final interview with Participant I, a cisgender female client was discussed. She initially met with Participant I for medication management, but began to disclose the traumas she was experiencing: “this male roommate of hers who, it turns out, had been taking advantage of her, sexually. She would pretend to be asleep, but she realized—I think what happens is, so often, with women, they blame themselves.”

All participants noted their clients’ traumas as essential in understanding the histories for this study. Each traumatic experience seemed to have “left a footprint,” impacted the way in which each individual navigated the world and personal relationships. The following section will discuss the relationship between the traumatic events and obsessive/ compulsive traits/ behaviors the clients experienced.

The link between traumatic experiences and OCD/OCPD. All nine participants conceptualized the relationship between the obsessive/compulsive traits/ behaviors and traumatic histories in their clients. The participants noted that the obsessive/compulsive traits/behaviors were a way to manage their internal experiences of stress/anxiety/emotions from the traumatic events and that the obsessive/compulsive traits/behaviors reflected their traumatic histories.

Participant A highlighted the connection between his client’s management of his internal pain through the obsessive/compulsive traits/behaviors. He described it as “whatever compulsive behavior they are doing to manage their anxiety. It’s like many things, like substance use. Drink away the pain. They are just trying to manage their emotions.” Furthermore, Participant A considered that the OCD symptoms may have been related to his clients’ past traumas. His client had to “double check everything” because he worked on a nuclear based and “all those habits

were reinforced... at one point the base was bombed and he had to watch that none of the inmates escaped.” Out of necessity, this individual had to be keenly aware of his and others safety and surroundings. However, once he left the military, his obsessions intensified and negatively affected his life.

One of the clients discussed had witnessed, experienced, and perpetuated physical violence throughout his childhood, and into his young adult life. Participant B explained that he believed the connection was about his client “controlling everything about... and around himself” and that was due to the trauma of witnessing his father beat his mother and then being beat by his brother. Participant B added that his client must have done this as a safety “measure” because he “developed a keen awareness of his surroundings” and his body. The client “hated weakness and his OCD was about focusing on eliminating weakness from his life and despising it when he saw it.” Participant B also reflected upon the cisgender female client with whom he worked. The trauma she experienced resulted in her believing that “she was insignificant and that no one was there to support her and that she needed to do everything herself.” As he (P-B) began to understand her recent relationship with a man, he noted that “she never felt a sense of connection and support from anyone else.” Participant B understood his clients’ organized schedule as way of “I need to make my surroundings make sense.” Her obsessive/compulsive symptoms seemed to stem from the abuse she experienced as a child.

Participant H believed that her clients’ traumatic history translated into his obsessive/compulsive traits/behaviors. When she initially met with him, she got the sense that underneath his obsessive thoughts were feelings of “guilt” and that “he was doing something wrong.” After a pause in the treatment, he began to meet with her (P-H) and disclosed to her his traumatic past. At this point she feels that he has “more awareness and is more able to reality-test

around the things that were contributing to obsessive thoughts and compulsive behaviors in response to the thoughts.” After several sessions, she began to note how his obsessive symptoms “related to things that are triggers of his trauma.” The clinician (P-H) noted that he had a deep fear of “breaking rules,” and when he was younger, he presented with hand-washing, door knob touching rituals that are not present today. His obsessive thoughts of “breaking rules” reflected his traumatic past.

Participant C shared that he felt his clients’ level of rigidity reflected his clients’ attempt to bottle up his “murderous rage” that he feels toward his father, military, and civilian superiors. Another participant (P-I) perceived that “OCD is just a manifestation of an attempt to survive... whether it’s panic... anxiety, depression... maybe it’s an attempt to control anger, then you’re not going to alienate people and then not belong.” Participant B conceptualized the obsessive/compulsive traits/behaviors as “coping mechanism[s] for traumas that someone has experienced... they have a sense of control over themselves or their environment.” The obsessive/compulsive traits/behaviors serve as management strategies.

Participant G was unsure as to whether the OCD symptoms reflected the traumas that his client experienced. The client would “get very anxious if anything in or out of his home is out of place. He is also focused on details of getting things absolutely correct at work and many times this causes difficulties at work,” as well as in his personal relationships. While he said he did not know enough about OCD to understand a potential the link between his client’s OCD symptoms and his traumatic past, Participant G believed that the OCD symptoms may serve as a way of “controlling” his environment.

Throughout the examples, all of the participants saw a connection between the obsessive/compulsive behaviors that attempted to manage the anxiety that emerged from the

memories of the traumas, but only several participants provided direct links where the symptoms replicated or expressed memory of the original trauma. Initially, Participant F believed the connection between his clients' OCD and trauma to be the instability of his fathers' presence. While that may certainly still play a role in the OCD, at this point, Participant F perceived a direct link between the obsessive/intrusive phrase "fuck you, god" that his client heard "repeatedly all day every day." His clients' obsessive/compulsive symptoms mainly emerged when he was 12 years old and "began to realize he was gay" in a conservative Christian environment where being gay was considered sinful. Participant F believed that his client held an enormous amount of rage at his faith community for the "negative messages that they were sending," and at his family for endorsing those beliefs. Ultimately, Participant F conceptualized that his clients' OCD emerged out of the "unspeakable dilemma of loving his family and being terrified that they would reject him." In this clinical example, the symptoms gave meaning to the traumas this man experienced.

In another example, Participant D's client wanted to explore the connection between his obsessive/compulsive traits/behaviors. During the interview, Participant D described how he and his client discussed the "meaning of these obsessions, and how they kinda tied back to his obsessions in Vietnam, obsessions he had when he was a kid, and this fear of something bad happening." Furthermore, the clinician and the client reflected upon the "self-soothing he engaged in in Vietnam and as a child that were important for him at the time but also led to this pattern of obsessions and compulsions to stop his obsessive thoughts." Participant D added that his client witnessed many individuals "flying off the handle," which was a primary fear of his. The client feared that if he walked past an alarm system, he would have to pull it; if he held a baby he would stab the baby; or he would randomly "strip naked or fight," and if he made the

wrong choice, he would be punished. As a child, he was always worried about “what was right what was wrong,” which stemmed from his “chaotic” childhood. This fear of making a “misstep” translated into a “theme that continued for life.” According to his clinician, in an attempt to avoid the potential consequences of, for instance, pulling the alarm, he would avoid walking past an alarm system.

This was not the first clinical example that Participant D observed where the clients who experienced "OCD and PTSD had really chaotic childhoods, unpredictable, sometimes they had very demanding parents that demanded perfection, obsessed about what was right and what was wrong.” He (P-D) noted that after trauma, OCD and trauma “blooms” for numerous individuals. Participant F also noted that he worked in a clinic “that attends to people’s religious histories and spiritual lives in the context of psychodynamic dynamic psychotherapy.” Over his many years there, he has been “struck” by the multitude of people who have experienced trauma in their “faith communities as children.” These traumas seemed to have “installed... a morbid preoccupation with right behavior, and a morbid fear of being damned. And [for] a number of these people, there is a later development of OCD/OCPD as an expression of that terror.” Participant E also stated that within her work, she has noticed many young adults who have experienced trauma and obsessive/compulsive symptoms as a result of that trauma.

Describing one of the younger adult clients, Participant E saw a connection between his obsessive/compulsive traits/behaviors and his past. When the client was found by child protective services: “he was living in filth, including his own filth. Sexually abused... physically abused, and probably, there are indications of traumatic brain injury at the hands of caregivers... his OCD manifests are protecting him from dirtiness.” The “filth” that this client experienced seemed to have affected him throughout his childhood into young adulthood; “he doesn’t like to

touch a lot of things with his hands” and the staff noted that “we have to approach” various activities “differently than” with the other clients. For example, when the clients are cooking or decorating for a holiday, the staff and client create a plan so that the client feels comfortable engaging with the activity, despite the cleanliness concerns. Another client of hers (P-E) ran from home the majority of his life. “OCD has served him as a sense of hypervigilance while he’s living on the streets.” This was noted in the clients’ need to “check” over his shoulder “all the time” and wondering “who is out to get me?” The interviewee (P-E) noted that the obsession was “interrupting his life.” She added that the other residents in the group home have noticed his need of “checking that the door is locked,” and that it must be locked “just right.” His obsessions/compulsives served as a protective factor (not allowing himself to leave the home) and were reminiscent of his past traumas.

The following theme discusses treatment considerations, modalities, and theoretical frameworks the participants utilize in their clinical work.

Mixed treatment considerations. Throughout the interviews, participants considered theoretical frameworks and treatment modalities that they utilized when treating trauma and obsessive/compulsive traits/behaviors in tandem and separately. The participants also discussed various aspects of the therapeutic work that they found supportive to the clients’ treatment.

All clinicians noted specific theoretical lenses that they applied throughout their clinical and macro work. Object relations, attachment theory, relational theory, internal family systems, ego psychology, self-psychology, and trauma theory were the psychodynamic theories that were considered supportive and effective in clinical work. One participant (P-A) did not utilize psychodynamic theory in his clinical work, and a majority of participants (P-B, P-C, P-D, P-E, P-F, P-H, and P-I) stated that they weaved in cognitive behavioral therapy (CBT) concepts into

their practice. Participant F stated that “I find CBT helpful as an adjunct... But we use when it is appropriate. But not in the classic manualized treatment model.” Despite it being considered an evidence-based practice, another participant (P-I) believed that “you can only do a little” with CBT.

Participants held varying perspectives on the primary theories that guide their trauma work, in contrast to specific work with reducing OCD symptoms. Some participants (P-C, P-D, P-F, P-H, and P-I) found psychodynamic theories as the primary theoretical framework and the most effective when supporting someone who has experienced trauma. Participant A was the only interviewee who found CBT to be the most effective theory to guide the work: “PE and CPT stuff is pretty effective, like it gets a little boring to me after a while cuz it is a protocol, you’re just doing the same thing, so it can sometimes be a struggle, but they are effective.”

However, despite the use of psychodynamic theory and practice for trauma work, several participants (P-A, P-B, P-C, P-D, P-E, P-F, and P-I) frequently cited CBT as an “effective” and/or supportive treatment modality aimed at the reduction of symptoms of both trauma and OCD. Specifically, prolonged exposure (PE), cognitive processing therapy (CPT), and exposure therapy continued to be referenced as the “evidence-based practices” that assist with reducing intrusive obsessive/compulsive symptoms. Dialectical-behavioral therapy (DBT) was mentioned by a couple of the participants (P-C and P-E) as a theoretical model that they lean upon. Solution-focused therapy was noted by one participant (P-A) as the model that he learned in graduate school and utilized in his current work. One participant (P-C) stated that utilizing an evidence-based therapy can help the “emergence of a statement” that was not conscious in therapy prior to that moment. Another participant (P-D) noted that “CPT and PE have been found effective for 80% of veterans in reducing symptoms.”

Regarding best practices of treating OCD/OCPD, apart from trauma, most participants (P-A, P-B, P-D, P-E, P-F, P-H, and P-I) agreed that OCD treatment should include some engagement of CBT, and other modalities should be utilized as well. Several participants (P-A, P-B, P-C, P-D, and P-E) noted a form of exposure therapy can be beneficial in reducing obsessive/compulsive traits/behaviors. A few participants (P-B, and P-I) stated that medication management and CBT should be utilized simultaneously. Two participants (P-G, and P-H) were unsure of what best practices were for the treatment of obsessive/compulsive traits/behaviors. Multiple participants (P-A, P-B, P-C, P-D, P-E, P-F, P-H and P-I) felt that getting a strong understanding of the clients' history was critical to treatment.

In asking about the treatment of OCD and trauma simultaneously, participants' responses varied. Several interviewees (P-A, P-D, and P-F,) considered that the obsessive/compulsive traits/behaviors may be more "pressing" than the trauma, and needed to be addressed prior to beginning the trauma work. Participant A described the "layers" of an onion and how "you peel one away, and then there is another layer... you have to do the OCD work to get to some of the stuff underneath. You start seeing the trauma, how they are related." Another interviewee (P-F) described how supporting someone who experiences both obsessive/compulsive traits/behaviors "involves... bilateral attention on the part of the therapist. One has to attend to both the trauma and OCD simultaneously. My experience in a longer-term therapy, ...and this can flip, in terms of what's more pressing." The same participant (P-F) shared with me that he wishes he had encouraged his client to start manualized CBT work earlier than he did, because this could have potentially reduced the amount of stress the client experienced. Another participant (P-G) wondered if both the trauma and the obsessive/compulsive should be treated simultaneously or if the traumatic events should be explored first to alleviate the symptoms of OCD.

As clinicians navigated the specific needs of their clients, an absence of literature regarding the connection between OCD and traumatic experienced was communicated in the interviews. Participant H stated that due to the lack of literature on the connection of obsessive/compulsive traits/behaviors, she is “just integrating my understanding of how to work with trauma and doing a lot of helping him to resource himself in managing the triggers that he’s dealing with right now.” Participant E noted that she believed that more literature needed to be presented for this unique experience.

The therapeutic relationship and clinical skills were considered. There was mixed consensus about how to navigate a treatment plan for someone who has a traumatic past and experiences obsessive/compulsive traits/behaviors. Participant C expressed frustration in his long-term work with an individual: “I don’t consider this treatment to be efficacious so far. I have not felt successful in puncturing his rigidity or his very thick carapace he meets the world with.” The clinician (P-C) additionally felt that he has not been successful in “pointing out... the ways in which he has a hand in his interpersonal difficulties because of the OCPD.” However, he (P-C) believed that the client “feels supported because he comes to therapy.” The client declined the clinicians’ suggested CPT protocol.

The participants also reflected on critical aspects of the relationship and what clinical skills were essential in supporting a client who has experienced trauma. Numerous participants (P-E, P-F, P-I, P-D, P-H, P-A, and P-B) viewed the therapeutic relationship as a corner stone of the therapeutic work. “Listening” to the client, “bearing witness to folks’ trauma,” and providing a “non-judgmental space” was considered critical to therapy and the therapeutic relationship. Creating a sense of safety in the therapeutic relationship and building “trust” was also considered an important element in all work with clients.

Finally, several participants (P-E, P-B, and P-I) discussed that the therapeutic work must be tailored to the client, and not to the diagnosis. One participant (P-B) believed that it is a “trap” for “therapists to use the DSM as a crutch.” Participant E highlighted that she does not “believe in one size fits all because individuals are so different and their neurology is so different.” Being open to “not knowing” was critical aspect of clinical work:

...being a detective and working alongside the client to explore and figure out what’s right, never to push one modality or one style of treatment, because they’re not all going to work... it’s good to take it slowly, help the client to guide their own—at the pace that is manageable for them... Be able to hold that there are going to be contradictions and... clinically, if you go by the DSM only, or by a certain modality only, it’s not going to fit. Knowing that, being able to hold that, and not being frustrated with it because they’re not textbook, because they bring to the table so much more and they carry that trauma in their bodies, in their brains.

Predominance of cisgender males. All of the interviewees presented on at least one client who had a traumatic past and presented with obsessive/compulsive traits/behaviors; some interviewees presented on more than one, so a total of 12 clinical cases were discussed. Out of those clinical cases, only two clients were cisgender females. Ten of the clients presented were cisgender males. None of the participants noted in their work that cisgender males serve as the primary population for people who have obsessive/compulsive traits or behaviors. However, the work settings of the participants may explain this finding; four of the participants presented on veterans, and the majority of veterans are cisgender males. Another participant currently works in a group home where all of the clients are cisgender males.

Conclusion

This chapter summarized and presented the findings of my study. Demographic data, treatment considerations, theoretical conceptualizations, and clinical cases were discussed. The concluding chapter explores the implications of the findings. More specifically, it examines how my research reflects and differs from the existing body of literature. Additionally, it includes further recommendations for future research.

CHAPTER V

Discussion

The objective of this study was to explore clinicians' perspectives on the association between OCD and trauma in the treatment of adult clients and how the symptoms of OCD and trauma reflect the traumatic experiences. After interviewing nine clinicians for a period of 40-120 minutes, the following key findings emerged: 1) all clinical case examples revealed traumatic histories, most stemming back to childhood; 2) obsessional/compulsive traits/behaviors manifested themselves in the clinical case examples as ways of managing internal and external stress and anxiety; 3) mental health professionals held mixed treatment considerations; and 4) strikingly more cisgender males than cisgender females were presented in the clinical material. This final chapter will compare the findings to the existing literature, explore the strengths and limitations of this study, and discuss the implications for future research and social work practice.

Comparing Findings to Existing Literature

Commonalities between clinical cases: Traumatic histories. All interviewees presented at least one adult client who had obsessive/compulsive traits/behaviors and a history of trauma. While only two participants noted that their clients experienced traumas as adults, the other seven participants reported that their clients had experienced childhood abuse. It was a requirement for the case presentations to include clients with trauma histories; all discussed clients did experience traumas, but the origin of the trauma varied. Some of the clients had

experienced multiple complex traumas, while other clients had lived through specific traumatic events. The data that emerged from these interviews reflects the current literature: trauma is a common occurrence, and over two-thirds of the American population have at least one traumatic event (PTSD Alliance, 2016). Individuals of all ages, races, religions, ethnicities, sexual orientations, as well as other identities can experience trauma. Traumatic events are not limited to specific events, and they are based on the individual's perception and response to the experience. Some of those experiences can include a single person or a group of people over a short period of time, or over generations. Traumas have the capacity to become more complex for an individual or a group of people, as they may experience more traumas.

The link between traumatic experiences and OCD/OCPD. Throughout the interviews, participants conceptualized their clients' relationships between their traumatic histories and their obsessive/compulsive symptoms. Two main implications emerged: as a result of the traumatic experience(s), the obsessive/compulsive traits/behaviors emerged as coping strategies that individuals used to manage their internal experiences, and the obsessive/compulsive symptoms reflected their traumatic histories. Although few previous studies explored a direct connection between the symptoms of OCD and individual trauma, the literature did reflect one of the main themes, which was that OCD is used as a coping strategy. Multiple participants conceptualized their clients' obsessive/compulsive symptoms as coping mechanisms for their experienced traumas.

The literature that does exist regarding the connection between traumatic histories and OCD points to a positive association (Caspi et al., 2008; de Silva & Marks, 1999, 2001; Gershuny et al., 2003; Lafleur et al., 2010; Pitman, 1993; Rachman, 1994 & 2004; Tolin et al., 2010; Wang et al., 2011). One study noted that there was a positive correlation between

childhood sexual abuse and OCD (Caspi et al., 2008), and another study in China (Wang, et al., 2011) noted that over three-fourths of individuals diagnosed with OCD had experienced trauma as children. An additional study found that youth who exhibited symptoms of OCD were more likely to experience emotional trauma prior to developing OCD symptoms (Lafleur et al., 2010). Many of the clinical cases presented by participants had experienced sexual, psychological, and physical abuse as children. The current study also supported previous findings that noted veterans were more likely to be diagnosed with OCD related to their military service, when they experienced cumulative traumas from their childhood (Pitman, 1993). Based on clinical case studies, de Silva and Marks (1999, 2001) proposed that the amalgamation of traumas exacerbated the obsessive/compulsive behaviors/ traits. Nevertheless, the same researchers (1999) were unsure whether the specific OCD symptoms discussed were strictly PTSD related or OCD.

One of the findings that emerged in my study was the conceptualization of OCD symptoms as a coping strategy of past traumatic experiences. All of the participants believed that they witnessed their clients attempting to manage their overwhelming traumatic pasts through the OCD symptoms. Within the small body of literature available on this topic, there are few studies that discuss and explore the appearance of OCD symptoms as coping strategies to cope with a single or numerous traumatic events. According to a couple of studies (Gershuny et al., 2003; Rachman, 1994, 2004), OCD symptoms may behave as coping mechanisms in an attempt to manage the traumatic experiences. Throughout my interviews, several participants believed that their clients' OCD symptoms acted as coping mechanism as a way of controlling their inner turmoil.

The majority of existing literature does not thoroughly explore whether OCD symptoms are reflective of a traumatic past, but a few research studies do. Rachman (2004) observed in his work that participants exhibit an increase in OCD symptoms after being sexually assaulted. Another study suggested that there may be a more significant meaning and connection of the OCD symptoms to the traumatic events (Gershuny et al., 2003). Despite this gap in the literature, several participants in the current study conceptualized their clients' obsessive/compulsive behaviors/ traits as reminiscent of their traumatic histories.

As a clinician, these findings underscore the importance of exploring the underlying concerns that may be triggering the behaviors, as well as the need to use a trauma-informed approach. The findings also help me comprehend the various ways in which people who have experienced trauma are doing their best to cope with the pain.

Mixed treatment considerations. As an aspect of the interview, participants discussed the theoretical frameworks and treatment modalities they utilized as they supported individuals who have experienced trauma and obsessive/compulsive symptoms, separately and together.

The majority of participants conceptualized their clients' experiences through psychodynamic theory because they found it effective and supportive in their clinical work. One participant did not use psychodynamic theory and primarily grounded his work in CBT. While most intertwined CBT into their work, participants did not perceive it as their main treatment modality. One researcher noted that CBT can be supportive in healing trauma, but not as the primary modality (van der Kolk, 2014). As stated in the literature review, both psychodynamic theory and CBT are considered effective theoretical frameworks as the foundation to clinical work (Greist & Jefferson, 2014; Youngner et al., 2014).

Psychodynamic theories were considered effective and supportive in clinical work and the treatment of trauma, while others noted that CBT, DBT, PE, and CPT were effective treatment modalities as well. Several researchers support all of these findings (Greist & Jefferson, 2014; Youngner et al., 2014). van der Kolk (2014) has stated that different forms of CBT may support some aspects of symptom reduction, “but it has not been proved to help with guilt or other complex emotions” (p. 223). While CBT has been studied in the treatment of traumatic disorders, CBT has not been proven effective for those who experienced child abuse (van der Kolk, 2014). Additionally, the majority of individuals studied noticed a reduction in symptoms but continued to experience the overall trauma symptoms. Several of the interviewed clinicians expressed their concern regarding the efficacy of CBT for treating underlying concerns. Few participants cited body-based therapies as healing modalities. However, van der Kolk (2014) and Thompson (2014) both believe that body oriented modalities, such as yoga, theater, dance, art, and music, are supportive for individuals who have experienced trauma.

Overwhelmingly, the majority of participants agreed that CBT is the best treatment modality for obsessive/compulsive behaviors/traits. Nevertheless, numerous participants stated that this evidence-based practice is limited in its ability to heal underlying concerns for clients. Additionally, the literature reports that CBT is consistently considered the most effective treatment for OCD (Greist & Jefferson, 2014; Youngner et al., 2014). Despite a literature gap surrounding psychodynamic OCD treatment, utilizing a psychodynamic framework may be useful for client support (Greist & Jefferson, 2014). Rachman (2004) believed that behavioral therapy alone may not be sufficient in OCD treatment.

Treatment modalities for the comorbidity of OCD and PTSD were sparsely investigated in the literature. Some researchers recommended that PTSD and OCD should be treated

simultaneously (Salkovskis et al., 1999). Two other researchers proposed that individuals must be screened for trauma when they are being treated for OCD (de Silva & Marks, 2001). Furthermore, should a traumatic history exist for an individual who experiences OCD, a treatment option that dives deeper than eliminating symptoms is suggested. Participants were unsure of the most fitting treatment plans, and these clinicians noted that absence of this specific literature made this treatment particularly challenging. Several participants navigated the treatment by addressing what they considered to be the most pressing of the presenting symptoms.

Treatment modalities and frameworks were considered important; nevertheless, other aspects of clinical support were considered. Multiple clinicians deemed safety as a critical facet of a therapeutic relationship and treatment plan, especially when working with individuals who have experienced trauma. According to Herman (1997), establishing safety in the therapeutic milieu is essential. Other critical aspects of therapy considered important elements of clinical work were “bearing witness” to their clients’ traumas, providing a “non-judgement space,” and allowing trust to build in the relationship. The literature supports these findings (Greist & Jefferson, 2014; Moss, 2009). Three participants noted that all clinical work must be tailored to each client, instead of a diagnosis. This was not reflected in the reviewed literature.

These findings emphasize for me how critical it is that we find the theoretical framework that works best for the clients’ needs. The therapeutic relationship is the cornerstone of successful psychotherapy, and that is why it is essential that therapists continue, through a trauma-informed lens, to bear witness in a non-judgmental manner to their clients’ stories and find the treatment modalities that match their clients. Regardless of their academic discipline, clinicians need to be open to the possibility that the individual we are supporting may have

experienced trauma. Because our clients do not represent cookie-cutter stories, we need to consider other alternatives to adhering to a select few theoretical frameworks. Utilizing multiple theoretical modalities only enriches clinical practice, not limits it.

Predominance of cisgender males. Overwhelmingly, 10 out of the 12 clinical cases presented were cisgender males. This finding does not reflect the existing literature. While cisgender men are more likely to experience OCD during childhood, cisgender women are more likely to be affected by OCD as adults. Out of the 10 cisgender males presented, it was not explicitly stated that one of the clients experienced childhood abuse. As noted in the previous chapter, the work settings of the participants could have affected the findings; four out of the nine participants presented on cisgender male veterans, which reflects the majority of that client population. Another participant worked in a group home for cisgender males.

According to the *DSM-5*, there are “higher rates of PTSD” (APA, 2013, p. 276) also reported by people of color than by white people, and individuals who are older are more likely to experience PTSD than younger people. Individuals who also experienced combat, sexual abuse, genocide, captivity, and internment are considered to be at an increased risk for developing PTSD (APA, 2013). Most interviewees did not identify their client(s) race or ethnicity, yet gender was always mentioned. This could have been reflective of the racial make up of interviewees, as they were predominantly white.

Strengths and Limitations of this Study

Strengths. This semi-structured study provided an avenue for clinicians to verbally present their clinical cases, their treatment, and psychotherapy beliefs regarding the connection between OCD and traumatic histories. Because this study was qualitative, it provided an open pathway for clinicians to share their experiences and explore a topic that is frequently not

discussed. Several of the interviewees reportedly “enjoyed” participating and having a confidential space to express their beliefs, frustrations, and clinical cases. A significant number of my participants were cisgender male social workers, a segment of the field that is frequently not studied. This study also built upon past research, examined the connection between OCD and traumatic experiences through clinical cases, explored relevant treatment modalities, participants’ demographic information, and whether a clients’ OCD symptoms are reminiscent of past traumas.

Limitations. With only 9 participants, this study did not meet the Smith College School for Social Work minimum requirement of 12 participants for qualitative research studies. There was also an absence of diversity within the sample; three participants were cisgender females, and the other six identified as cisgender males. Another limitation was the lack of racial diversity, which could be attributed to my professional connections. Over half of the participants were currently practicing in Massachusetts, four were Smith College School for Social Work Alumni, and seven were social workers. This could have been due to my level of access to various social media groups affiliated with Smith College School for Social Work alumnae and because I am a resident of Massachusetts. This study’s findings cannot be generalized beyond these participants due to the sample’s size and lack of diversity and because of the nature of qualitative research itself.

Implications for Social Work Practice

This study certainly raises critical questions about the tandem treatment of trauma and OCD in adult clients. As previously mentioned, CBT is considered to be the most effective treatment for OCD, while trauma treatments include psychodynamic, CBT, and body-based modalities. Given the findings, the consideration of utilizing multiple modalities and theories is

recommended in the treatment of OCD and trauma. Numerous participants noted that the integration of multiple theoretical frameworks and treatment modalities has ultimately been supportive to their clients. While numerous studies site CBT as the most effective treatment method for OCD, utilizing body-based and/or psychodynamic therapy is integral, especially when an individual has experienced trauma.

Several participants shared that they were unsure of how to proceed regarding the best treatment for their clients who experience OCD and trauma. After analyzing the findings, I believe that it would be beneficial for a treatment model to be created or explored regarding the supportive aspects of treating traumatic experiences and the development of obsessive/compulsive behaviors/traits as an aftermath to trauma. At a minimum, traumatic histories should be assessed when working with clients who present with obsessive/compulsive behaviors/traits. As suggested by my participants, utilizing a trauma-informed lens is critical when working with clients with a variety of concerns, including OCD. This study highlights how as clinicians, we cannot be wed to a specific theoretical framework, but draw upon multiple theories to best support our clients. Utilizing numerous treatment methods in supporting one's practice will richen the clients' healing and personal growth.

Implications for Future Research

All future research has the potential of expanding the knowledge on trauma and how it affects trauma survivors. As my sample size did not reach the minimum number of participants originally required and proposed, it is recommended that future research should have a larger sample when focusing on the relationship between OCD and traumatic experiences in adults. Increasing racial, gender, and professional composition of the participants is highly suggested. Since several clinicians in my study mentioned that they were undecided about the most

advisable route to take when supporting clients who present with OCD and traumatic experiences, additional research regarding treatment considerations should be undertaken. Future research could replicate this study with clinical case studies of children or with clients from varying cultural, ethnic, and racial backgrounds. Obsessive/ compulsive traits/behaviors can hold different meanings depending upon the population of interest. Given that cisgender men mainly comprised the clinical cases, further investigation on cisgender male trauma survivors should be conducted. While children were not the focus of this study, exploring the connection of OCD and trauma in greater depth in children is recommended to further the understanding of the relationship. The majority of clients presented experienced childhood abuse. Conducting further research could assist in earlier intervention. In addition, future research could explore OCD treatment and psychodynamic theory.

Finally, future research could include neurofeedback treatment with OCD and trauma. Neurofeedback, a type of biofeedback, is a non-invasive, drugless treatment that rewires the brain, aiming to improve overall function and self-regulation. Fisher (2014), the psychotherapist who introduced van der Kolk to neurofeedback, stated: “with neurofeedback we hope to intervene in the circuitry that promotes and sustains states of fear and traits of fearfulness, shame, and rage. It is the repetitive firing of these circuits that defines trauma” (p. 316). According to van der Kolk (2014), neurofeedback also reduces anxiety, enhances attention capacities, learning disabilities, and boosts mood. In the studies that van der Kolk (2014) has conducted, he has observed positive significant shifts for trauma survivors.

Little research has been conducted on neurofeedback as a treatment for OCD. However, the current research found that individuals who experience OCD can benefit from neurofeedback treatment. One study (Hammond, 2003) reported that it can decrease intrusive thoughts and

obsessive and compulsive behavior. This study also found that it can reduced depressive symptoms, anxiety, somatic symptoms, and decrease social anxiety (2003). The simultaneous neurofeedback treatment of OCD and trauma could prove to be an effective method of healing.

Conclusion

This study reveals important insight into the relationship between OCD and trauma experienced in adult clients and provides treatment considerations for the treatment of trauma and OCD. The OCD symptoms discussed were found to be reflective of past traumas, and the OCD symptoms were manifested as coping mechanisms. Overwhelmingly, the clinical cases presented by the participants described cisgender adult male clients. Ten out of the 12 clients presented experienced childhood abuse. Future research needs to be organized to deepen the understanding between the relationship of OCD and trauma, and fundamentally, expand our understanding of how trauma can affect individuals.

While many clinicians utilize evidence-based practices, such as CBT, the findings of this study revealed that CBT may not be sufficient as the sole treatment modality when an individual is experiencing both OCD and trauma. However, one treatment modality may be sufficient in treatment. It is imperative that social workers and clinicians from other fields consider utilizing multiple treatment modalities and theoretical frameworks, while using the therapeutic relationship and their therapeutic skills to optimize healing. Each individual experience is unique, and therefore a single treatment modality will ultimately not be supportive.

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Appendix A: HSR Approval Letters



School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

January 27, 2017

Alexandra Pansovoy

Dear Sasha,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 2, 2017

Alexandra Pansovoy

Dear Sasha:

I have reviewed your amendments and they look fine. You did a beautiful job. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten', written in a cursive style.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 29, 2017

Alexandra Pansovoy

Dear Sasha,

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

April 10, 2017

Alexandra Pansovoy

Dear Sasha,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor

Appendix B: Informed Consent Form

2016-2017

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....
Title of Study: An Exploration of the Relationship Between Obsessive-Compulsive disorder and Traumatic Experiences in Adult Clients

Investigator: Pansovoy, Sasha
.....

Introduction

- You are being asked to be in a research study that explores the connection between Obsessive-Compulsive Disorder (OCD)/Obsessive-Compulsive Personality Disorder (OCPD) and traumatic experiences in adult clients, and whether the symptoms of OCD/OCPD are reflective of the trauma that an individual experienced.
- You were selected as a possible participant because you are currently or a previously practicing social worker, psychologist, psychiatrist, or other mental health professional, who has practiced for a minimum for 1-2 years, post graduate school, trauma-informed, and has worked with a client who exhibits obsessive and/or compulsive traits/ behaviors, and as a history of trauma.
- Prior to beginning the interview, you had a phone conversation with the researcher regarding the nature of the study and whether you meet the criteria.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore the connection between OCD/OCPD and traumatic experiences in adult clients and whether the symptoms of OCD/OCPD are reflective of the trauma that an individual experienced. The relationship of OCD/OCPD and trauma is not well understood, so this study would be contributing to the body of knowledge already present. Deepening the understanding of this connection may provide further knowledge for clinicians.
- This study is being conducted as a research requirement for my Master’s in Social Work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: sign the consent form, and participate in a 45-60 minute confidential in person or video chat interview at a private location of your preference (such as your office, or my office, instead of a public space such as a café. Your interview will be audiotaped for future transcription and analysis of the data.

Risks/Discomforts of Being in this Study

- This is a low risk study, and this interview likely will not distress the participating clinicians. However, should you experience distress and wish for a referral, I will provide a list of referrals for counseling at the end of the interview.

- Should identifiable client information materialize, I will ask you at the end of the interview whether I should exclude particular information from the interview. If identifiable information emerges, then it will be removed from the transcript and excluded from the write-up.

Benefits of Being in the Study

- The potential benefits of participation are strengthening case presentation skills and gaining a deeper insight into the presented case, as well as other professional work.
- The relationship of OCD/OCPD and trauma is not well understood, so this study attempts to fill the gap of literature that explores this relationship.

Confidentiality

- Your participation will be kept confidential. To ensure confidentiality, interviews will be kept separate from the signed consent forms. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.
- Please de-identify the case(s) you will be presenting. Should any identifying details about the case emerge, I will ask you at the end of the interview whether there is any identifiable information. Should any emerge, I will remove it from the transcript and omit it from the write-up.

Payments/gift

- One participant will be randomly selected to receive a \$25 gift card to Starbucks or Target.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely voluntary. You may refuse to answer any question or withdraw from the study *at any time* up to June 1, 2017, without effecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by June 1, 2017. After that date, your information will be part of the thesis and final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Sasha Pansovoy at _____ or by telephone at _____. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. At the time of the interview, you will be given a signed and dated copy of this form to keep. At that time, you will also

be given a list of hotline numbers if you experience distress related to your participation in this study.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

.....

I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

Appendix C: Recruitment Letters

Hello,

I am writing to invite you to participate in an interview with me as part of my Master's thesis, which focuses on the relationship between traumatic experiences and Obsessive-Compulsive Disorder (OCD)/ Obsessive-Compulsive Personality Disorder (OCPD) in adult clients. This research study is particularly important to me because of the work I have done with individuals who have experienced trauma. Additionally, this study attempts to fill the gap of literature that explores the relationship between trauma and OCD/OCPD.

This study is a requirement for completing my Masters in Social Work degree at Smith College School for Social Work. To be eligible in this study, the participant must be a practicing or retired social worker, psychologist, psychiatrist, or other licensed mental health counselor. The participant must be trauma-informed (participated in at least one trauma focused training), and who has practiced for a minimum of 1-2 years post graduating school. Finally, the participant must have an adult client they can present who exhibits obsessive and/ or compulsive traits/ behaviors and has a history of trauma.

This study includes reading and signing an informed consent and participating in a 45-60 minute, in-person or video interview with me. Due to ethical requirements and confidentiality, I am unable to interview anyone for my thesis with whom I am already acquainted. At any point during the interview or until June 1, 2017, the participant can withdraw. One participant will be randomly selected to receive a \$25 gift card to Starbucks or Target. If you would like to participate in this study, or know someone who may be interested, please contact me or have them contact me at _____ or _____.

Thank you for considering participation in this study. Your perspective matters, and clinicians have the power to make an impact on the way we support survivors of trauma.

Best,

Sasha Pansovoy, B.A.
Master's of Social Work Candidate
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Hello Friends,

I am currently completing my Master's Thesis at Smith College School for Social Work. My thesis explores the relationship between traumatic experiences and Obsessive-Compulsive Disorder (OCD) Obsessive-Compulsive Personality Disorder (OCPD) in adult clients. This research study is particularly important to me because of the work I have done with individuals who have experienced trauma. Additionally, this study attempts to fill the gap of literature that explores this relationship.

To be eligible you must be:

- A practicing or retired social worker, psychologist, psychiatrist, or other licensed mental health counselor.
- Trauma-informed (has participated in at least once training focused on trauma)
- Practicing for a minimum of 1-2 years post graduating school
- Discuss an adult client with whom you have worked with, who exhibited obsessive and/ or compulsive traits/ behaviors and has a history of trauma.

This study includes reading and signing an informed consent and participating in a 45-60 minute, in-person or video interview with me. Due to ethical requirements and confidentiality, I am unable to interview anyone for my thesis with whom I am already acquainted. At any point during the interview or up until June 1, 2017, the participant can withdraw from the study.

Please share with others you think would be eligible/ interested in participating in this study. If you would like to participate in this study, or know someone who may be interested, please contact me at _____ or _____.

One participant will be randomly selected to receive a \$25 gift card to Starbucks or Target.

Thank you for considering participating in this study. Your perspectives matter, and clinicians have the power to impact the way we support survivors of trauma.

Best,

Sasha Pansovoy, B.A.
Master's of Social Work Candidate
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix D: Interview Guide

Brief Statement about Study Before Interview Begins:

Hello, and thank you for taking the time to participate in my study. Participating in this study is voluntary, and if at any point you wish to withdraw from the study, you may do so. This study is about the relationship between traumatic experiences and OCD/OCPD in adult clients. We will be discussing this for approximately the next hour. The audio recording of this interview will be kept in a password protected computer file. Should any client identifiable information emerge, please inform me at the end of the interview. If you inform me of identifiable information, I will remove it from the transcript and omit it from the write-up of this interview. Do you have any questions? Recording will not start until you sign the consent form.

I. Demographic Information

As a way of beginning, how would you describe your education and training regarding your clinical work?

- Where did you attend graduate school?
- When did you graduate?
- What kind of setting do you work in now and what settings have you previously worked in?
- What are the populations you currently support?
- What are theories that you primarily utilize in your work?

II. Questions about Trauma

How do you define trauma and what has been your experience working with people who have experienced trauma?

- What does trauma-informed mean to you?
- How does your trauma-informed training inform the way you work with clients?
- What theoretical frameworks do you use in supporting individuals who experience trauma?
- What is your understanding of best practices in supporting individuals who experienced trauma?
- What treatment modalities have you found effective in your work with trauma?

III. Questions about OCD/OCPD

How do you define OCD/OCPD and what has been your experience working with adult clients who experience OCD/OCPD?

- What training have you received surrounding OCD/OCPD?
- How does your OCD-related training inform the way you practice?
- What theoretical frameworks do you use in supporting individuals who experience OCD/OCPD?
- What is your understanding of best practices in supporting individuals with OCD/OCPD?
- What treatments have you found effective in your work with OCD/OCPD?

IV. Questions about the relationship between OCD/OCPD and Trauma

What has been your experience working with people who have experienced both OCD/OCPD and trauma?

-As you know from our phone call, can you talk about a case of someone you treated who had both OCD/OCPD and trauma?

-What kinds of traumas did this person experience?

-What were the diagnoses made?

-How is the OCD/OCPD and trauma connected?

-How do you conceptualize this link?

-What are your clinical perspectives on the client's symptoms of OCD/OCPD and traumatic experiences being related?

-In your experience, what would be the recommended treatment modalities and clinical considerations that could be supportive for a client who experiences trauma and OCD/OCPD?

V. Closing question: Are there any things you want to share with me that we've not covered on the relationship between OCD/OCPD and trauma?

Thank you for your time. Your recorded interview will be stored in a safe place. Once I have confirmed that the audio recording of the interview is saved on the recording device, the recording on my cellphone will be automatically deleted. After the interview is transcribed, the interview will be deleted off the recording device and stored in a password secured file on my laptop. One of my study participants will be randomly selected to receive a \$25 gift card. Do you have any questions? Again, I thank you for your time.