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Addiction Research

Addicted to Control or Trying to Control The Addiction? Structures and Mechanisms of OCD - Two Track Conceptualization

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ABSTRACT

As clinicians specializing in the treatment of patients who suffer from Obsessive Compulsive Disorder (OCD) and those suffering from other anxiety disorders, the Covid 19 pandemic had revealed surprising features of these patients' coping mechanisms. We observed that while the general population reported an increase in anxiety levels and associated symptoms, patients suffering from OCD reported less anxiety and stress than before the pandemic. While the feeling of uncertainty in almost all life domains was the predominating experience of the general population, OCD patients surprisingly reported experiencing a reduction in stress. As psychotherapists, we were fascinated by this phenomenon and attempted to investigate the origin of this paradox. In this paper, in order to contain the complexity of OCD in both the theory and practice of it's treatment, we present a two-track approach to the disorder involving the structures and mechanisms of addiction.

Keywords

OCD, Addiction, Control, Anxiety, Stress, Adrenaline.

People who suffer from OCD experience recurring, intruding sensations, thoughts, and ideas (obsessions) that make them feel impelled to conduct repetitive actions (compulsions) [1]. These repetitive cycles significantly interfere with the person's daily functioning as well as their social interactions. A lot of people experience preoccupation with troublesome recurring thoughts, as well as behaviours which they regularly repeat. However, these may contribute structure to their daily lives and some necessary functions require repeated actions in order for them to be more efficient such as brushing teeth before going to sleep and when waking up. On the contrary, the repetitive behaviors of OCD are distracting, non-functional and eventually elevate stress and tension even more. Most of us associate behaviours such as hand washing, cleaning, organizing, checking or counting our steps with OCD [1]. However, in fact, OCD can take a variety of forms, which are not always easy for people to recognize in themselves, nor are very obvious to the observer, thus making the phenomenon more difficult to identify, diagnose and treat at its early stages.

According to Colon-Rivera and Howland [1], OCD develops from a strong sensation of anxiety aroused by recurring threatening thoughts [1]. Although for the observer, the conviction of the person suffering from OCD tends to appear unfounded, the person suffering from the disorder is convinced that the threat is very real, and possesses practical implications. In this process, internal conviction develops concerning actions which the person should conduct in order to prevent the realisation of the danger resulting from the threat [2]. Under the instruction of the OCD mechanism, the person develops a mystical belief in the efficiency of the compulsion dictated by the disorder, which it is necessary to conduct in order to reduce the danger in real occurrence, providing him with immediate relief. This results in an illusionary feeling of control over external occurrences which he believes to be very real. The person also possesses internal and absolute conviction that if he does not take the necessary action (compulsion), the likelihood that the worst scenario will soon occur is certain. This conviction is usually based upon his internal omnipotent thinking and the person suffering from the disorder can provide a rational explanation for the protocol of activities.

The complexity of the structure and mechanisms of OCD requires a profound investigation into its etiological roots as well as the development and progress of the disorder. Moreover, many features

of OCD are closely related to the structures and mechanisms of both primary and secondary, as well as cross addictions. For this reason, early diagnosis is crucial.

The basic concepts underlying compulsive, impulsive and addictive behaviours overlap, and some authors and practitioners use these definitions interchangeably. Although research has made a large effort to better define and disentangle these behaviours, both practitioners and scientists are still unable to clearly differentiate between them. Therefore, obsessive-compulsive disorder (OCD), impulse control disorders (ICD) and substance-related disorders (SUD) overlap on various levels, including neurochemistry and neurocognition, phenomenology as comorbidity, neurocircuitry, as well as family biography. Lubman, Yucel and Pantelis, [3] suggested that malfunctional behaviours and high relapse rates in individuals suffering from chronic addictions, may be viewed as 'compulsive' activities which are a result of dysfunction within inhibitory brain circuits. This explanation may provide a rationale for why addicts tend to lose control over their drug use and persistently revert to self-destructive behaviors of drug-seeking and drug use, while sacrificing other essential activities in their lives [3].

Meyers and Dick [4] presented a number of genetic and environmental risk factors which are known to be related to the development of addiction. These account for about half of a person's risk for its development. The contribution of epigenetic risk factors to the total remains unknown. Nevertheless, it is known that when individuals with a relatively low genetic risk are exposed to sufficiently high amounts of an addictive drug for a long period of time (such as weeks–months) this can result in an addiction [4].

Lubman, Yucel and Pantelis, [3] claimed that although control-related cognitions have often been implicated in discourse related to Obsessive Compulsive Disorder (OCD), scientific inquiries related to the relationship between 'need of control' constructs and OCD symptoms are still insufficient (Lubman, Yucel and Pantelis, 2004). Moulding and Kyrios [5] found that higher levels of the desire to control and low levels of sense of control were associated with high levels of OCD-related beliefs and symptoms. They also concluded that control cognitions were linked with the OCD-related beliefs of perfectionism and the overestimation of threat [5].

The concept of control and whether the feeling of loss of it is the basis of the disorder of addiction as well as OCD is a largely reviewed topic in both psychology and medicine. Therefore, we suggest the two track conceptualization that links between the two disorders.

The first track conceptualization of the etiology of OCD suggests the view of the need for control as the origin of the development of the OCD structure and mechanism. Obsessive compulsive patterns involve both anxiety, the feeling of helplessness and the need to experience a sense of control. In this view, these arise from a history of growing up with anxious parents which the child experiences as denying him of his own control over his life in some way or another, e.g by intrusiveness or over involvement in his personal space of development. Often, when a child experiences helplessness he is driven towards an illusion of omnipotence in his imaginary world, in which he can play within many imaginary ideations. This mechanism can be protective for the child but at the same time it can become very confusing and frightening for a child who needs to know that he has strong parents whom he can rely upon. Therefore, he may develop anxiety due to the sense of control and omnipotence. A child growing up in such an environment may spend more time in his imaginary world, either by play or narrating, becoming obsessed by thoughts concerning imaginary occurrences and his efficient role in controlling them. In the structure of OCD, the obsessive thoughts intrude the individual psyche in an anxiety arousing manner, while the compulsion prevents the content which is the focus of the ideation from occurring. In this way the individual both preserves the omnipotent illusion and decreases his anxiety levels. This mechanism nurtures itself through repetition of the cycle. Thus, it could be closely related to the structure and mechanism of addiction.

In the second track conceptualisation of OCD proposed here, the etiology is related to the notion that people become accustomed to a certain level of stress and the biochemical state related to it. During childhood, the environment which the parents provide becomes the 'baseline' state of arousal for the child in which he feels comfortable. When the environment changes causing a change in the stress levels, due to their discomfort, most people strive to make changes in order to revert to the stress levels they are accustomed to. This can be done through either passive or active inference. Passive inference will mean adapting themselves to tolerate the new circumstances. If they cannot adapt to the new stress level which is too high for them, they will develop anxiety, and if it is too low for them they will feel bored or depressed. They can also try to actively change the external situation which comprises active inference. This may take the form of an activity which effectively causes the stress inducing circumstances to cease or be reduced, or to perform an activity that raises the stress levels if he is bored due to lower stress levels to those to which he is accustomed. Anxiety may be caused by a variety of thoughts which enter our mind while we are not performing any particular activity, and is possibly the sensation which leads to the fastest and strongest state of arousal. In OCD, a person may intentionally or unintentionally repeatedly recall an anxiety-inducing thought which led to a state of arousal in order to experience that desired arousal again and again. If the thought is morally unacceptable to him or suggests a forthcoming potentially traumatic event, but obsessively recurs in his mind, the person begins to believe that it is real. He then may develop a protocol of activities which he must compulsively conduct in order to prevent the imminent disaster from occurring. These activities are derived from omnipotent thinking and provide the person with a sense of control over the circumstances.

It is common for people who feel that they lack control over their lives, to seek out both primary and secondary addictive behaviors

which are not mutually exclusive. For some people, this can happen more during certain difficult periods of time. However, for others it is a persistent way to manage their experience of lack of control over their lives. Grant and Chamberlain (2020) relate to addiction as a biopsychosocial disorder indicated by repeated usage of drugs, or persistent engagement in an activity such as gambling, although this involves harming the self and the others (Grant and Chamberlain, 2020).

Primary addiction is related to a behaviour that provides the individual with an immediate sensation, which is desirable for him, encouraging him to repeat it, in order to achieve the same goal. Some people achieve this through competitive sports, others by riding a motorcycle in an urban area, while some find the thrill of gambling irresistible. These activities provide the person an adrenaline rush which elevates him/her to the stress-homeostasis which he is accustomed to, accompanied by a sense of excitement and euphoria. In a similar way a certain emotional state and especially anxiety, can fulfill a function for us which is the creation of a physical or biochemical state which we are accustomed to. Some of the physiological changes in the body which result when experiencing excitement are identical to those which occur when experiencing anxiety.

Secondary addictions are a temporary relief for a person's troubles or a way to forget their problems for a limited period of time. The addictive behaviour or substance is used to correct another issue, and also in some way in order to avoid the feeling of sadness or stress. Thus, secondary addiction occurs easily when a person rehabilitates from an unwanted primary addiction replacing it with another which is more acceptable to him. In this sense, the compulsive activities of OCD can be viewed as a secondary addiction which replaces the primary addiction to the stress-related state achieved from the initial troublesome thought (obsession). The compulsive protocol of activities will reduce the anxiety which led to a level of arousal which became unpleasant for the person and led to a sensation of loss of control.

Therefore, OCD serves the function of escape from an internal emotional state of anxiety. Sometimes the activities which the person compulsively conducts have no logical connection to the initiating emotional issue, and simply serve the function of preoccupying the person and preventing him from thinking about the anxiety provoking state. The sufferer's desire to avoid dealing with the troubling emotional issue, facilitates the existence of the obsessive compulsive disorder and fuels its continuation. As long as the person denies the existence of the issue, he will continue to create in his mind imaginary circumstances and interpretations whose role is to distance him from coping with it. Only profound emotional introspection and courage enables him to identify the specific emotional issue.

Bringing the patient to an understanding of the cause and development of his OCD in accordance with one of the above tracks or their combination, is the initial step of the rehabilitation process. According to Salari, Hosseinian-Far, Jalali, Vaisi-Raygani, Rasoulpoor, Mohammadi, Rasoulpoor and Khaledi-Paveh [6], during the current Covid 19 pandemic, the fear of infection and uncertainty in many domains of our lives has increased the anxiety levels of the general population [7]. For people who actively sought after the physiologic state of stress in order to achieve the homeostasis they were accustomed to, the pandemic provided the stressogenic circumstances which they required. If the etiology of OCD is related to a conscious or unconscious addiction to a state of excitement caused by an obsessive anxiety-inducing thought, sufferers of OCD need to pay less attention to their internal thoughts because real-life events are providing them with the adrenaline.

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