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Emotional Injury OCD – Overlooked and Misidentified

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Abstract

Obsessions of physically harming others are common in OCD. Current inventories largely do not include obsessions of emotionally injuring others, of diminishing another's perceived value or worth. This may reflect a low prevalence rate or specific barriers to identification. Hypothesized barriers to clinical identification of emotional injury OCD include the atypically pleasant presentation of characteristic affirming compulsions. Patient self-identification is hypothesized to be diminished by the nature of overt and mental compulsions; for instance, agreeing with others and self-criticism. Recommendations are provided for differential diagnoses with social anxiety and codependency, as well as specific contraindications for common psychotherapeutic approaches. Hypothesized comorbid pathology are presented as opportunities for initial identification of cases. In establishing an a priori conceptual framework, this overlooked and misidentified OCD subtype can better be assessed, researched, and effectively treated.

affirming compulsions; codependency; emotional injury OCD; social anxiety

EMOTIONAL INJURY OCD – OVERLOOKED AND MISIDENTIFIED

1. Introduction

The identification and prevention of compulsions is critical for the successful treatment of obsessive-compulsive disorder (OCD) [1]. Indeed, the absence of response prevention of compulsions was a primary reason OCD was untreatable well into the 1960s [2].

Compulsions can, however, be easy to miss. Individuals with OCD are often adept at concealing their symptoms and may characteristically doubt their own pathology. In one longitudinal study, individuals with OCD went undiagnosed on average seventeen years after initially experiencing symptoms [3].

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Good clinical assessment can help. Measures such as the Y-BOCS [4], DIAMOND [5], and OCI-R [6] list commonly recognized compulsions to use in the identification of OCD.

Still, it may be that some compulsions remain missing in our inventories. In this paper, we wish to explore one such possibility, those compulsions that would most directly neutralize obsessive fears of allowing or causing *emotional injury* to another. *Emotional injury* is defined as psychological pain caused by another, typically related to a sense of diminished value or worth.

2. OVERLOOKED

Atypical Compulsions

Obsessive fears of causing or allowing harm to others are common in OCD, characterized by an inflated sense of responsibility [7] for others' well-being, paired with a low tolerance for un-

certainty [8]. However, OCD inventories rarely include obsessive fears of causing or allowing emotional injury. This may indicate a low prevalence rate of the subtype, or it may be that resultant compulsive symptomology is routinely overlooked.

Compulsions resultant of harm-based obsessions are often focused on the prevention or repair of harm; for instance washing or cleaning to prevent or remove contamination. How then might a person with emotional injury OCD prevent or repair emotional harm? The individual could engage in repetitive *affirming* compulsions, compulsively affirming others' importance. The logic would follow: *if I can perceive evidence I made you feel important then I can feel more certain, at least for now, I am not responsible for allowing or causing emotional injury*. These compulsions would avoid the risk of triggering new emotional injury obsessions by inconveniencing, aggravating or burdening others; for instance, as is the case with more direct, repeated reassurance seeking. In the following table, we provide a list of proposed overt affirming compulsions that could neutralize emotional injury obsessions.

Table 1. Affirming Compulsions

Compulsion	*Example/Description*
Agreeing	*I couldn't agree with you more. You are so right! I have never thought of it that way before.*
Apologizing/Self-Blame	*It is all my fault. I am so sorry. I promise it will never happen again.*
Aspiring	*I wish I could do that as well as you.*
Attending	*Just wanted to see how you are doing. How have you been? Tell me what is going on.*
Credit Giving	*I don't deserve any of the credit. If it weren't for you, none of this would have happened.*
Deferring	*I like your idea way better. I don't know what I was thinking.*
Deflecting Blame	*That is not fair! You didn't deserve that. You did everything right.*
Nonverbal Affirming	Gazing with deference and admiration; voice constriction; eye lowering.
Obeying	Obeys direct commands (e.g., bring me a sandwich) as well as implied commands (e.g., *I am hungry*).
Owing/Gratitude	*I can't thank you enough. I really owe you.*
Praising	*You are amazing! It is truly remarkable what you can do.*
Proving	*I'll do whatever it takes. I won't let you down.*
Self-Diminishing	*I just got lucky.*

Affirming compulsions may be easily mistaken for socially prescribed behaviors. They are, however, functionally the same as other compulsions: preventing or reducing obsessional anxiety or distress, and/or preventing some dreaded situation. So too would an affirming compulsion need be in excess of what is normal, well outside the reach of norms. In short, they would be pathological, just as behaviors like handwashing that are desirable in moderation become pathological when performed rigidly and in excess, in response to obsessional fears.

Overt affirming compulsions would too be unique in the catalogue of overt compulsions as they are characteristically pleasant to others. This atypical presentation makes affirming compulsions particularly easy to miss.

Indeed, Muris et al.'s research confirms it is not the type of ritualistic behaviors that differentiate individuals with OCD from those in the general population but rather the frequency and intensity of those behaviors, as well as the intensity of associated obsessional distress [9]. Muris et al.'s research further suggest clinicians struggle in the identification of atypical compulsions. It is this clinical bias toward identifying compulsions based on form over function that has hidden emotional injury OCD in plain sight.

Suggestible

If clinicians have overlooked emotional injury OCD symptoms, why then have individuals

with emotional injury OCD not identified those symptoms in themselves?

Consider the nature of the hypothesized symptoms. If another person (for example, a clinician, a researcher, a family member) were to offer a mischaracterization of the individual with emotional injury OCD, that would necessarily trigger an obsession, fearing the other person would feel insulted and diminished if not affirmed. Consequently, the person with emotional injury OCD would engage in compulsions such as agreeing, to neutralize the fear. Unfortunately, absent any existing assessments or conceptualizations of their pathology, individuals with emotional injury OCD have been all but guaranteed to receive and consequently accept mischaracterizations and dismissals of their symptoms.

It is likely too that individuals with emotional injury OCD would engage in mental compulsions that limit their ability to disagree. For instance, mental compulsions such as internally agreeing with others, internally praising others, self-diminishing, and self-criticizing, would each reduce distress associated with obsessive fears of causing emotional injury. These mental compulsions, in turn, would have an additional facilitative effect on overt affirming compulsions. For instance, internal agreeing with others would make it easier and more believable to engage in overt agreeing, internal praising of others would make it easier and more believable to engage in overt, praising compulsions, and internal self-criticism and self-diminishment would make it easier to apologize and agree with others.

The heightened suggestibility resultant of these processes would effectively explain why individuals with emotional injury OCD have not meaningfully self-identified. Not only would the individual be unlikely to overtly disagree out of obsessional fear, but so too would they struggle to disagree internally. In sum, so long as researchers and clinicians do not recognize symptoms of emotional injury OCD, people with emotional injury OCD would be exceedingly unlikely to recognize them in themselves.

Finally, were an individual with emotional injury OCD to become aware of their pathology, additional barriers to self-identification would remain. Individuals may fear that bringing attention to their symptoms could inconvenience or shame family or other close associates. Additionally, they may fear that sharing with loved ones their diagnosis of emotional injury OCD could emotionally harm others by bringing into question the authenticity of affirming and caring behaviors in the past. This obsessive fear may pose a particular challenge at the onset of treatment. When present, it may be necessary early in treatment to identify referential memories where the client has experienced acting in a caring manner from a non-anxious, congruent place, setting this as a benchmark for meaningful experiences and a goal for treatment. A person with emotional injury OCD can and should be able to delight in others and be genuinely loving and kind when not consumed by obsessive fear; the goal would be to have even more moments where this is the case. However, as is the case more broadly in OCD treatment, no additional reassurance should be provided after the initial psychoeducation stage.

3. MISIDENTIFIED

Social anxiety

Emotional injury OCD is based in a fear of being responsible for emotional injury to another rather than a fear of personal diminishment, as is the case in social anxiety. The person with emotional injury OCD would characteristically believe: *it would be terrible if I allowed or caused another person to feel less than* whereas the person with social anxiety would characteristically believe*: it would be terrible if someone made me feel less than*.

Accordingly, one of the clearest differentiators between emotional injury OCD and social anxiety would be the degree to which the individual is comfortable with and even welcoming of self-deprecation, self-blame, and downward comparisons from others. For instance, a person with emotional injury OCD should welcome downward comparisons as evidence of the others' positive emotional state, so long as the downward comparisons does not diminish another person by association. From a treatment perspective, it might be helpful to encourage a person with social anxiety to increase their tolerance for personal diminishment; however, it would be actively countertherapeutic for an in-

dividual with self-blame and/or self-diminishment compulsions.

That individuals with emotional injury OCD have compulsions is too a meaningful differentiator from social anxiety. Although interpersonal in vivo exposures may be effective both for individuals with social anxiety and emotional injury OCD, treatment for emotional injury OCD is set up for failure absent targeted response prevention of overt and mental compulsions.

Avoidance may too present differently in emotional injury OCD and social anxiety. For instance, avoidance of other people may be triggering for the person with emotional injury OCD if they fear they would indirectly offend others by providing insufficient attention or disappointing others via their absence. No such resistance to avoidance should be evident in social anxiety.

Avoidance may, however, become increasingly appealing to individuals with emotional injury OCD as they progress through treatment. This may be particularly relevant in cases where a client has habituated to the obsessive fear of ignoring others but not to the fear of saying or doing something that could more directly harm another person's self-worth. In such instances, the relative absence of distress when alone may lead individuals to actively seek solitude. While this behavior may superficially resemble avoidance seen in social anxiety, the underlying motivations are distinct. Therefore, it is crucial to assess the historical presence of compulsions and to clarify whether the individual's social fears are rooted in concerns about harming others or about personal rejection or humiliation.

Codependency

Individuals with emotional injury OCD may be mistaken for individuals who are helpful to others because they crave reciprocal affirmation. As is true in OCD more generally, however, pleasure should play no part in cases of emotional injury OCD.

If anything, most wants and desires are likely to be noticeably suppressed in individuals with emotional injury OCD, particularly in social contexts. In many cases, receiving affirmation from others may elicit anxiety, especially if individuals fear that such affirmation could lead others to feel diminished by comparison. This presentation contrasts significantly with individuals who display a strong need for frequent affirmation and who may exhibit irritability when such affirmation is withheld. The latter pattern more closely reflects a dependency dynamic, akin to Baumeister and Vohs' conceptualization of an addiction to esteem [10].

The individual who craves being needed by others would more closely identify with the following: *it would be terrible if others did not need me to tend to them*. Individuals with emotional injury OCD, in contrast, would more characteristically identify as such: *something terrible would happen if I ever stopped tending to and affirming others.*

These two presentations may be mistakenly conflated in broad, vague constructs such as codependency, further obscuring the existence of emotional injury OCD.

Consider, for example, the following two profiles drawn from a frequently cited list of codependent traits [11].

The first individual exhibits characteristics such as externalizing blame, deliberately provoking others, taking themselves overly seriously, experiencing low mood in response to a lack of external validation, believing they know best how others should behave, feeling angry and underappreciated, becoming self-righteous and defensive when criticized, attempting to catch others in misbehavior, and displaying a general mistrust of others.

In contrast, the second individual internalizes blame, fears eliciting anger in others, minimizes their own importance, dismisses praise, considers their own contributions unworthy of attention, more readily expresses anger on behalf of others than for personal injustices, engages in excessive self-blame, frequently apologizes for their presence, and lacks trust in their own emotions and judgments.

Both profiles are *codependent*. Both individuals engage in frequent helping behaviors and have impairment in their interpersonal relationships. But effective treatment for one is unlikely to resemble effective treatment for the other.

The failure to differentiate these two presentations is much more than a taxonomic error. Not only are approaches to treatment tailored for codependency unlikely to be effective

for individuals with emotional injury OCD (for instance, missing critical features like response prevention) but so too may certain treatment approaches be actively harmful.

Consider, for example, interventions such as maintaining a gratitude journal. While this practice may benefit individuals who experience persistent feelings of underappreciation and a perceived entitlement to affirmation, it would be strongly contraindicated in cases involving compulsive expressions of gratitude. Similarly, interventions that emphasize radical acceptance of others may inadvertently reinforce both overt and covert compulsions related to excessive praising or agreement. Likewise, practices aimed at reducing attachment to self-importance or personal desires may unintentionally exacerbate compulsions involving self-effacement, submissiveness, or excessive compliance.

In treatment for a person with codependency, it could be helpful to practice attending to others' wants and needs without trying to control. For the person with emotional injury OCD, this same practice would likely compound preexisting attending, deferring and agreeing compulsions. Even sharing with the individual with emotional injury OCD the misguided conceptualization that their compulsions are controlling and directed at personal pleasure could be dangerous, actively reinforcing self-suspicion and dismissal of personal wants, compounding proving and self-diminishment compulsions, and/or encouraging interpersonal avoidance.

4. CONCLUSION

Any advancements in diagnostics and treatment for emotional injury OCD would be a significant step forward. Until now, even if an individual with emotional injury OCD were to present to treatment, treatment was set up for failure, lacking as it were the proper identification of compulsions to be targeted via response prevention. Fortunately, existing empirically-supported treatments for OCD such as Exposure and Response Prevention should be well-suited to the treatment of emotional injury OCD [12].

It is nevertheless crucial to adapt existing interventions to the specific clinical presentation of emotional injury OCD. For example, compulsions involving obedience and excessive agreement may be inadvertently reinforced by a clinician's misinterpretation of symptoms or by the application of overly directive therapeutic strategies. In some cases, a directive stance may be employed deliberately to induce a therapeutic tension between the compulsion to affirm the clinician and the compulsion to affirm others. However, it is imperative that such a clinical double bind be clearly explained to the client, with careful attention given to ensuring that the dynamic is not prolonged unnecessarily.

The ability to accurately and consistently identify symptoms of emotional injury OCD may also help uncover cases in which previously unrecognized features of this subtype contribute to treatment resistance in comorbid conditions. This may be particularly relevant in presentations of treatment-resistant forms of co-occurring OCD subtypes. It is well-documented that individuals with OCD often meet criteria for multiple subtypes over the course of their lives [13]. If emotional injury OCD is routinely misclassified as social anxiety, this may partially explain the high lifetime comorbidity rate of 43.5% between OCD and social anxiety disorder [13]. Similarly, treatment-resistant eating disorders may represent overlooked instances of emotional injury OCD, especially in individuals who experience obsessive fears of causing affiliative shame to others through their physical appearance [14,15].

Given the existing barriers to self-identification and clinical assessment, it is critical to establish an a priori conceptual framework for emotional injury OCD to facilitate the accurate identification and empirical study of this atypical presentation. Improving our understanding of emotional injury OCD holds significant promise for the delivery of efficacious, much-needed treatment for a long overlooked and misidentified population.

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