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Hidden figures: a somatic and relational approach to healing OCD

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Abstract: This article aims to show that Obsessive–Compulsive Disorder is not a disorder but a creative adjustment and a meaningful coping response to an early traumatic environment. Stemming from her long-term experience practising cognitive behavioral therapy, the author describes how this approach is often ineffective and contraindicated for traumatised individuals and introduces a longer-term somatic and relational approach based in Gestalt therapy. The author shows that the reinstatement of a client's stalled separation–individuation process is at the heart of healing OCD. The phenomenological unfolding and treatment of Obsessive–Compulsive process in the present moment is illuminated through several case studies, each one demonstrating an aspect of treatment including: the use of Winnicott's 'transitional object' as metaphor to deconstruct fixed figures and expand the contact boundary, the relationship between OCD and preoccupied attachment, and the use of mind–body interventions derived from developmental somatic psychotherapy. The author emphasises that viewing OCD as a process rather than a pathology can help drastically to reduce clients' shame and reorganise the relational field so healing can occur.

Keywords: Obsessive–Compulsive Disorder, creative adjustment, trauma, cognitive behavioral therapy (CBT), relational, preoccupied attachment, separation–individuation, developmental somatic psychotherapy (DSP).

'We hold in the places we weren't held.' (Ruella Frank (personal communication))

'We're children of God before we're children of our parents. It may actually take some time for an infant to de-infinitize… To actually come into the realization that I have to be where my body is, that my body is this bounded packet, really takes quite some time and some sophistication.' (Michael Eigen, in Molino, 1997, p. 106)

Introduction: the need for a new treatment approach

After ten years of administering cognitive behavioral protocols (CBT) to adults and children at a large teaching hospital in New York City, I joined a CBT program there for adults and children with Obsessive–Compulsive Disorder. I did this with some reluctance given OCD's reputation for being incredibly challenging to treat.

Out of my large caseload, only one client experienced mild relief through CBT. The rest were too terrified to comply with 'exposure and response prevention therapy' (ERP), which involves gradually exposing a client to his feared situations. Trained as a Gestalt and psychodynamic therapist, I felt that CBT completely missed the essence and depth of these clients' suffering, so while I continued in this setting I focused on discovering what the missing components were, in order to help these clients heal.

Seven years ago, I began treating clients with OCD in private practice. Several clients from around the world contacted me because they feared exposure therapy or because after completing CBT their symptoms returned in new configurations. ('I resolved my "contamination OCD" but now I have "harm OCD".') I unintentionally retraumatised one client who insisted we do exposure. At that point, it finally clicked for me that all of these clients had felt traumatised by their early environments to varying degrees. Their OCD symptoms were creative adjustments serving to contain their encoded childhood relational traumas. Their symptoms held them together when their environment could not.

CBT clinicians acknowledge that we need alternate approaches for OCD, since one out of four clients refuse exposure treatment altogether (Maltby and Tolin, 2005) and 20% drop out of treatment (Schruers et al., 2005). I believe CBT has its merits and I adapt aspects of it

in my practice; however, despite a few limited recent studies (Doron et al., 2009; Rezvan et al., 2013), I have not found it helpful for my clients. One major limitation is that CBT takes clients' fears literally ('you fear HIV, let's touch needles') when, undoubtedly, their fears are relationally shaped *symbolic* communications (e.g. 'I'm terrified of expressing my anger towards others'), even if also genetically influenced. Because it is considered evidence-based, CBT has been marketed as the 'gold standard' in OCD treatment, which has created a landscape of suspicion for clinicians who are not doing ERP and shame for clients who feel like failures if they choose to pursue different treatment. CBT misses the overwhelmingly relational, traumatic and somatic issues that shape the development of OCD. Chronic dissociation, affect dysregulation and a diminished sense of embodiment – all major indicators of trauma – have been underestimated and misunderstood because of the larger psychiatric world's current reliance on CBT and narrow bias towards anything that cannot be standardised or has 'inadequate conclusive research' (Huppert et al., 2005). Furthermore, CBT seeks to eliminate symptoms that serve as the fragile thread that keeps many clients from unravelling into psychosis.

I have found that a somatic and relational approach based in Gestalt therapy has been highly effective with these clients, substantially reducing the intensity of their symptoms and enabling them to live more freely. The work is complex and a client often needs to invest in a year or more of psychotherapy; however, he can *heal*. What helps heal OCD is the therapist's *belief* that the client was never broken: he was traumatised. Holding the possibility of healing in the field, the therapist reshapes the client's view from one of intrapsychic blame to compassion for his field experience.

In this article, I aim to illuminate the gaps missed by CBT and psychodynamic approaches and to offer new theoretical understandings (developed through phenomenological inquiry and Gestalt experiments) and directions for healing.

OCD is a contacting style, a meaningful co-creative expression that arises from a traumatic relational field. Immersed in the OCD experience, I unexpectedly discovered and healed traumatic pieces from my own childhood. When clients learn to understand their obsessive–compulsive patterns within a safe holding environment they can disentangle their life energies from their traumatic narratives and reorganise their entire relationship to life.

OCD: definitions and functions

OCD is traditionally defined as the experience of having *unwanted, repetitive, intrusive thoughts, images and impulses* (obsessions) that cause anxiety, guilt, doubt and uncertainty. To relieve or undo the distress caused by these obsessional themes, a person may engage in rituals (compulsions). Typical obsessive thoughts include fears of harming oneself and/or others, becoming contaminated by germs or contracting diseases or being imperfect (forgetting things, not noticing errors). Compulsions can include hand washing, avoidance, ordering objects symmetrically, tapping, or seeking excessive reassurance, and may be experienced only mentally.

Typically, people diagnosed with OCD spend many tortured hours of each day stuck in painful obsessive–compulsive loops characterised by noticing a distressing thought and then negating it through some ritualised external or mental action to calm their anxiety. For example, if someone has a blasphemous thought about God, which they feel is 'bad', they may negate it by mentally thinking a 'good' thought about God. This cycle is both exhausting and terrifying, often causing severe functional impairments interpersonally, professionally and internally.

In this article, I reframe OCD as '*OCP*' – *obsessive–compulsive process* – because I see it as a meaningful coping style, and labelling it a disorder risks further shaming these clients, many of whom have already introjected enormous shame.

How an obsessive process forms

We all call on OCP periodically when the ground presents larger threats than we are able to face. Reorganising a messy sock drawer or repeatedly checking our bank account acts like netting in the gap between this known moment and the unknown next. These rituals block out the greater threats of the background, enabling us to narrow and simplify our experience to more manageable figures in the foreground. They *temporarily* contain and soothe our fears, offering us an illusion of control, mastery and a sense of consistency when other means of reliable support are lacking.

An OCP becomes a fixed and painful way of relating – a habitual response – when the environment is repeatedly *experienced* as traumatic, i.e. filled with 'overwhelming experiences that cannot be integrated' (Ogden and Fisher, 2015, p. 29). When parents are too filled with their own unconscious traumas or unable to access a felt sense of comfort from their own history, parts of the child's emerging energies – her feelings, sensations, impulses (id functioning) – are not received and fail to assimilate. Rejecting in herself what felt unwelcome and often *harmful* to her caregivers, these rejected feelings become unconsciously paired with a sense of dread or chaos. The child develops a fear of these feelings which is the hallmark of OCD.

To protect herself from drowning in this state of inchoate dread, and primarily to create a sense of safey and control, the client creates her own life-saving container by binding her original fear with an OCP – a set of stories, rituals, 'repetitive loops' (Jacobs, 2003, p. 38). She slams the lid shut so she can experience herself as 'going on being' (Winnicott, 1975, p. 303), enclosing herself within some known, fixed, safe lines. Though this container imprisons her, it enables her some space, some place to withdraw into and push away from the original terror. Lost to her conscious awareness, she experiences these dissociated thoughts and feelings associated with the original fear situation as hostile intruders; they feel alien to her because they were disowned.

In the face of both 'the too fixed figure' and 'the too charged ground' (Perls, Hefferline and Goodman, 1951/2009, p. 59; hereafter PHG), the client creatively adjusts by manufacturing her own alternate world of illusory figure and ground, thus at least setting out to 'do something' to counter the unbearable helplessness and creating some meaning and order rather than losing herself to a meaningless world of terror. The more chronic and pervasive the overwhelm, the more reliant she becomes upon OCPs as her reference point. It is important to appreciate the resourcefulness of this defence because even if the client is fighting a losing battle (with OCP it ultimately is), it is a battle she can face, devote herself to and mobilise *against*. This offers her some sense of agency and some sense of other, some companion to relate to in a world permeated by horrific isolation.

In more severe experiences of OCP, clients not only experienced their feelings as unwelcome, but they also faced intrusive parental hostility and criticism which left them feeling chronically petrified and unsafe.

Preoccupied ground, preoccupied attachment

Clients with OCPs are gripped by an energy of preoccupation. Their preoccupation manifests in their struggle to release the false figure in the foreground, which they believe is the true cause of their distress (e.g. 'if only I could figure out whether I am a paedophile or not'). This foreground conflict initially *needs* to remain unresolvable until clients feel safe enough to approach the unarticulated and painful hidden figure in the background that *truly* motivates their desperate search – their ambivalent attachment.

The hidden figure impinges on the client constantly and unconsciously so that he lives somewhere *between* the figure and the ground (which never empties). Unable to reject or resolve the ambivalence he feels towards caregivers he also depends on, he withdraws from fluid contact with himself into his OCP in order to remain confluent with his parents' expectations. His OCP becomes a mother substitute and though it is his best attempt to regulate himself, it also expresses his excruciating dilemma: 'I can't live with you or without you'. A client's reluctance to push away and release his thoughts also represents his inability to push away and release the mother he could never safely attach to.

For example, Jane, age thirty-four, had struggled with OCD since childhood. Raised as a devout Christian, she sought therapy because she felt plagued by frantic existential questions about the meaning of life and relational dilemmas ('Am I bad for doing that?'). To counter her anxiety, Jane engaged in compulsive prayer to appease God for her being a 'bad Christian'. These reassurance-seeking rituals intensified when 'something felt off' between Jane and someone she loved. We made the connection that these rituals emerged as a mother substitute. When Jane was a child, her mother did not know how to soothe her adequately, instead encouraging Jane to 'see what the Bible said'. Sensing her mother was depressed, Jane recalls confessing to her when she felt she did something 'bad', to gain reassurance that she was 'a good girl'. She also recalled soothing herself as a child by lining up her dolls every night until things felt *just so*. 'If they were in order, *I* could feel in order and get through my day.'

During a session, when Jane was panicked and trying to *figure out her feelings*, we slowed down and breathed together, and I invited her to sense her body and go deeper into her experience. She allowed her fear and uncertainty to emerge and develop into feelings of sadness, though she felt terrified ('What if I drown in my sadness?'). When I sat beside her to comfort her, she sobbed for the first time, expressing how painful it felt to be comforted, 'because this comfort feels like home – like something I never got – and now I'm afraid I will like it and it will end, so I never go to that place because I fear what if I never find it again?'

Sensing her body more closely helped Jane learn to recognise how quickly she jumped to ritualise in moments of uncertainty. We worked with this place by inviting the scared child part of herself forward so it could voice its fears and helped her access an internalised comforting presence – a way to physically and verbally soothe herself through those moments. We also addressed Jane's need to seek reassurance from an external authority (e.g. the Bible) by helping her begin to trust her own inner knowing.

Underlying OCPs is the loss of a *longed-for, reliable, comforting other* who never came, the despair that support will never come and the grief underlying the belief that one can only rely upon oneself. It can take a long time before clients are able to touch this place in therapy.

The space between and around experience

A key characteristic for many people with OCPs is their inability to feel space around their experiences and between themselves and others. Things and people feel *too close up, fused with oneself*. There is a lack of a sense of boundaries and separation.

To calm their terror, clients with OCPs employ mental vigilance to try to access a feeling of 'just rightness', when what is missing is a full-body experience of letting go. When a safe other makes space for us, we can soften into their presence and/or their bodies and into our own, and a sense of space opens up within us. In this space, we release our pressing internal contents, sense our minds moving to the background and fully inhabit ourselves. Repeated moments like these contain and absorb us, transforming energies that previously felt threatening into tolerable ones (Bion, 1977, p. 27). They create a sense of an 'other' – who is separate from us – a container for our contents (and therefore an experience of self) – both of whom are large enough to hold our experiences. (Bion's theories substantiate this, though not with specific mention of OCD.) This experience of self and other as container reveals that we are not our fears but that which holds them – and when these figures are released, we and the other go on. Contacting then feels safe.

These moments of 'final' and 'post contacting' were lacking for people with OCPs. Lacking a safe and reliable enough ground of an 'other' *from whom* to find relational support and the shift in perspective which space affords, these clients experienced little distinction of figure as separate from any ground – as self separate from an 'other' and from their arising experiences – and therefore little observing ego. They feel as if they *are* their experiences (which is why they attach to every thought). Many live primarily in this one terrorising part of themselves that has hijacked them so that their fear never truly finishes.

OCPs as partial symbolisations

The capacity to symbolise – 'to evoke the absent object, to anticipate the future, to conceptualize, and to communicate' (Meetings of the New York Psychoanalytic Society, 1971, p. 383) – is an indispensable process for children's developing relationship to life. It is the process by which something comes to stand for something else and therefore matures from being the thing itself. When a mother's loving presence came often enough, we can symbolise her internally by recalling a felt sense of her (Stern, 1985). A shark puppet comes to stand for and be a vehicle for a child's anger. Through play, as through being securely held, we become the master of our experiences rather than their captive.

I believe that in the obsessive experience, the symbolisation process partially fails to complete itself, even if it also helps organise the client (as it does when later life trauma causes an individual to form an OCP). OCPs then paradoxically come to symbolise *what failed to happen*; they are a child's depiction of the 'stories about the bad feelings that never went away'; fairy tales deprived of their happy endings. OCPs represent unrequited relational and energetic dilemmas – the hug that never came, the mistake that could not be forgiven, the impulse that lost its way.

In the obsessive field, one's fears remained literal because one's feelings never lost their initial threatening charge allowing them to mature and become *just feelings*. If one never learned that 'a hug can fend off *the fear of death*' (Francesetti, 2017, p. 11, original italics), then one is always literally feeling that one *is* at war with death. When a client's fears fail to lose their power, he is left with a lingering horrific darkness that symbolises his inner and outer uncertainties. He projects his fears outward so that his world feels filled with germs and demons, in which he has to be ever vigilant because danger seems to lurk around every corner. This terror also remains inwardly. Fearing that something disturbing can jump out at him at any time from the inner ground of his being, he is afraid of the space that emerges between this figure and the next because he has never lived in a non-preoccupied state. These fears force him to withdraw into an alternate universe where he is suspended and immobilised between worlds – afraid to move forward into life or inward to explore his psychic life. His failure to symbolise reflects an environment of early trauma. When a child has to be so hypervigilant, he is too afraid to play or explore. Therapy works to unearth his lost narrative and fearful parts to help them mature from partial to full symbolisation.

The transitional object: the use of metaphor

I began to frame OCPs with some clients as metaphors for transitional objects (Winnicott, 1971/2005). OCP is a client's contact boundary regulator. Like a child's beloved teddy bear that she takes with her to help navigate the transitions in her life and allows her parents to interact with, the client's OCP is like a transitional object. She too brings it with her to the therapist in the transitional space or the contact boundary, but the difference is that hers is a stalled symbol, which fails to represent the mastery and joys that are normally born of the separation process (ibid.). Instead her symptoms express the distress that immobilised her transition from confluence with her family to differentiation.

While most clients feel intense shame in sharing their symptoms, many express endearing attachment to this inanimate symbol of their experience because it still offers the vehicle through which they are 'waiting to be *found*' (ibid., p. 63). I introduce clients to this metaphor saying, 'It's sort of like a security blanket though not quite, because it also causes you distress. But it is familiar and it helps you feel safe when you don't know how else to be with your feelings.' I also make the link that OCPs intensify when the ground begins to push forward to help clients gradually make the connection, 'Oh, I must be anxious about something else right now if I'm in this loop'. As a client develops trust in the therapeutic alliance, she will allow you to gently nudge, transform and revitalise this weak figure and deepen the contact boundary into something livelier, facilitating the transition from the literal to the symbolic. For example, instead of narrowly spending the session recruiting you to help her figure out if she contaminated someone, you widen the ground and ask her *what it feels like* to believe she *is* 'contaminated', gradually creating space for new figures to emerge from the ground – e.g. her sadness – so that her story can reorganise. Talk of transitional objects evokes powerful imagery and remembrances of security blankets, stuffed animals and clients' experiences of often pronounced separation anxiety and terrible ambivalence. OCPs are their ambivalent companions.

Case example

George, a man in his sixties, struggled with anxiety and some OCPs around perfectionism since childhood. He struggled with some OCPs around perfectionism, which intensified eight years ago when, as a successful corporate lawyer, he was sued several times. This led him to 'have a breakdown' (he had to stop working, his life fell apart) resulting in the development of PTSD and simultaneous obsessive–compulsive fears of contracting HIV. His compulsions included avoiding close contact with all people (due to fears of them having open wounds and giving him HIV) and needing constant reassurance. He also drank heavily to manage his anxiety. George received several outpatient and inpatient CBT treatments but found the exposures of hugging contaminated needle containers too frightening. He has been seeing me twice a week for four years.

Initially, George insisted his fears of contracting HIV were literal, rarely allowing me to shift the topic away from his fears in order to have him sense his body. One session, he shared a realisation that he feels as if he is carrying a fragile vase around wherever he goes which he can never put down. He expressed fears of dropping it and breaking it. The vase was a metaphor for how breakable he felt. It became our shared metaphor, a transitional object representing the fragile nature of our contacting, and a physicalisation of his OCP and his inability to release this fixed figure.

The vase metaphor opened up exploration of George's childhood experience of having to be confluent with extremely high parental expectations. He had to become a successful lawyer, and getting sued was a huge shame. 'I realise the core of my distress was my childhood. *There was no me*. There was a *false me*. It was all about them until something in me couldn't take it anymore.' George realised that his whole life was organised around a fixed idea of 'not fucking up' symbolised by not 'breaking the vase'.

George's HIV fears of mistakenly contracting a 'shameful' disease symbolised his fears of being rejected and shamed. Somatic experiments with proximity (e.g. me entering his personal space) revealed that contracting HIV also symbolised his fear that people can invade and harm him, revealing his inability to set boundaries between himself and others because his psychological space was never honoured.

Initially, I used the vase as a metaphor for his fearful contacting style in our sessions. I would ask him about our connection or his feelings and he would say, 'This isn't related to my OCD; can we get back to it now?!' His sense of humour enabled me to redirect the sessions and ask him, 'Would you be willing to put the vase down for a few minutes and see what happens?' Gradually, he saw his fear and allowed more space between his attempts to stay in control and his ability to be more vulnerable with me, enabling him to face the greatest fear in OCP, the fear of being disturbed (Dan Bloom, personal communication, 2015) and disorganised through contacting. He now relies on OCP much less and allows himself to be more open to his experience in session. The space between us (the contact boundary) has opened up from fixed to more spontaneous contacting and he has been able to tolerate his feelings more, experiment with polarities ('being the irresponsible and careless bad boy') and ritualise less. Though his symptoms have dramatically abated, George acknowledges recovering from OCD is a slow process: 'My real "exposure" now is accepting the messiness of my feelings, of real life and learning I can cope.'

Conceptualising and physicalising OCP as a transitional object or companion allows the client to deepen his understanding of his conflict and to do what he could not do as a child – regulate how much contact he wants instead of feeling compelled to shape himself around others. This offers him both deep relief and a sense of agency.

Somatic pieces of the work

Noticing and experimenting with the qualities and functions of a client's habitual movement patterns reveals hidden figures that represent a client's preverbal kinaesthetic learning, which can be less accessible through talk therapy. Developmental Somatic Psychotherapy (DSP), developed by Ruella Frank, defines six movement patterns that are co-created in a child's first year. These patterns are physical and relational supports for contacting and reflect how we learned to inhabit and shape our bodies in relation to our parents. Helping clients identify and strengthen these patterns strengthens ego functioning and decreases reliance on OCPs. Here, I briefly highlight the push pattern because of its striking diminishment in the obsessive–compulsive experience.

The extent to which we can *push* informs us how available and reliable the other was for resistance and feedback, how easily we could take space from and negotiate our distance and differences from others in our families (Frank and La Barre, 2011). When pushing is diminished, we feel uncontained, helpless and fused with our experiences and with others.

Pushing: the process of separating and developing agency

The push pattern has also been figural in my own life. I had difficulty separating from my mother due to unassimilated multigenerational wounds in my family. My grandparents were Holocaust survivors and so in our family the experience of separation was tantamount to death. Having explored the push pattern in years of bodywork sessions, I became curious about its potential relevance in helping my clients. I adapted an experiment from the DSP model to explore what my clients' movement patterns revealed relationally. The client and I would face each other and play with pushing a small ball between us, as a way of sensing how we meet one another.

What I discovered when I gently pushed the ball into their personal space was that over thirty clients who were struggling with OCPs expressed a startling and repeated commonality in different ways. Despite apparent discomfort, all of them avoided pushing me away, allowing me to intrude on their personal space. While the relational field with each client was unique, in exploring their responses, all of them revealed the same *fear of harming the other through separating (pushing)*: 'I don't want to push back because I'm afraid I will hurt you'; 'I feel like I have so much power to hurt you'; 'I can't protect my space with you, just like I can't with my mother. I'm afraid to hurt her (or anyone) after all she's been through, even though I feel so angry.' As children, these clients felt they had to sacrifice standing their ground to preserve a connection to their parents. They all shared fear of harming a parent – usually mother, though sometimes father – coupled with chronic vigilance to *ensure no further harm occurred* to the parent. These experiments revealed the presence of unhealed multigenerational or ancestral wounds which crowded the early field, and which these clients absorbed as children. Hooking into the wounded child parts of their parents and often their experience of the parent's ambivalence about their separation, they felt too responsible and unable to disengage from their parents and their parents' unassimilated fears.

These clients struggled to access their push; their necessary energy for establishing their difference from others compromising their *sense of agency and active initiative*. Pushing includes the ability to say no, to walk away from, take space, establish boundaries and express anger and disgust. It enables us to protect and prioritise ourselves and feel a sense of privacy to our experiences.

Clients with OCPs often describe feeling as if they 'lack skin', 'feel raw and exposed', 'wished I had some armour', or feel 'too porous', therefore their fears that 'things can just get in' make sense. Movement work helps them develop a felt physical and *energetic* experience of boundedness (a sense of skin), enlivens their sense of self as active agent/doer and provides experiences of power and satisfying contact and release. 'Acting the aggressions, the organism *fills out its skin* and touches the environment without damage to the self' (PHG, 1951/2009, p. 345, emphasis mine). When pushing experiments are adapted to provide clients with more feedback than they experienced growing up, they begin to differentiate between the past and the present, so that their exaggerated fears (that their aggression is too powerful or persecutory or that their actions are too heavy for others) can reconfigure into a safe outward-moving energy. The 'magical thinking', 'omnipotence of thoughts' and 'overvaluation of thoughts' (the belief that thoughts are equivalent to action) (Freud, 1955, p. 86) that define OCPs are gradually transformed.

Somatic interventions invite clients to claim and occupy more of their bodies, awakening them to a sense of their body boundaries and, therefore, a felt sense of their bodies (self/ego) as containers for their feelings**.** Both children (for whom unresolved separation anxiety often expresses itself through OCPs), and adults who learn to push more by experimenting with setting boundaries, in time, rely less on OCPs because they learn that life feels safer when we more clearly sense our bodies and our sense of agency. The energy that was bound up in fear and confluence becomes available for creating powerful lives of their own and clearer, more vigorous figures.

Therapy suggestions

OCP is a container for clients' unassimilated traumatic experiences when another safe container was not available. Because these clients' traumas were chronic and developmental, there was no single defining event. Therefore, CBT research that administers self-report questionnaires to pinpoint discrete 'Criterion A' trauma events entirely misses the point, because people with OCPs are dissociated from their traumas and cannot name them. *Their trauma was that they never felt safe enough to be themselves*. Their trauma symptoms include terror and dysregulation when certain feelings arise, a belief that the world is 'more dangerous than safe' and a tendency to scan for threats to their survival. When triggered, many clients exhibit shallow breathing and an inability to take in the reassurance they repetitively ask for because they cannot shift out of a state of fight or flight and access a calmer state of being – a parasympathetic response. Feeling terrified, they vacate their bodies for their minds, staying on the surface of their experience, afraid to go deeper into their feelings and trust themselves. Their curiosity for life remains undiscovered because when survival is foreground, curiosity cannot emerge. Most do not meet the full criteria for PTSD and I believe this is because OCP contains the traumatised parts of the self.

Therapy with these clients is like taking them by the hand and nudging them out of the narrow tide pools they got stuck in, escorting them back into the wider river of life by teaching them that feelings do finish and that life is safe enough to be lived. This shift in perspective – from a state of hypervigilance to a life that is enjoyable – is not, as CBT posits, something one just easily surrenders behaviourally, because it is an entire rerouting of a client's sense of self and a life organised around fear and fixed beliefs. These beliefs are held on multiple levels of one's experience – somatic, cognitive, affective and interpersonal; therefore, therapy needs to attend to all of these levels. Releasing rituals requires clients to push away from what was familiar (including a complicated family connection), propelling them forward into a new life. (These clients struggle most with transitions.) If clients have not been helped to carve out a new life structure for OCP-free living, they will feel as if they are moving forward into a terrifying abyss and will just recreate their OCPs.

An additional challenge is that clients' fixed ideas are highly syntonic. Since aligning with fear and doubting themselves always felt safer, loosening fear structures will initally 'feel wrong' to them and they will have to tolerate these fears of uncertainty. Therapy involves helping them develop self-compassion and an entitlement to comfort and fear-free living. Focusing on how their OCPs deny them the lives they long to live can strengthen their motivation to tolerate the feelings underlying their beliefs.

Gestalt therapy is a good modality for treating OCPs because of its expertise in working with moment-to-moment unfolding process and helping clients notice when they leave the present moment to ritualise, though sensitivity to trauma and dissociation is key. Gestalt's emphasis on somatic experience is essential for these clients because of their diminished sense of embodiment. Though not all clients are initially receptive to somatic work, over time most become open to sensing when they feel dysregulated and learning how to self-regulate through breathing and being present together. This helps unpair their arousal from their fear stories, and replaces attempts to centre themselves conceptually through thoughts and rituals with centring in their bodies and in relationship. Holding the notion of a transitional object can help clinicians feel less pressured to 'fix' these issues, which these clients push for.

Besides the safe therapeutic alliance, clients need tools that help strengthen their sense of self as container so they can better navigate the feelings of uncertainty that surface as they gradually release their rituals. Some tools include: Gestalt exercises on orienting, strategies for shifting mind and feeling states and creating space from thoughts (taking walks, breathing, 'flow' activities, meditation), affect tolerance, work with movement patterns, and creative experiments in session designed to disorganise and loosen fixed figures.

Therapy can be very frustrating when clients are stuck in obsessive–compulsive loops. Appreciating the functions of these patterns helps establish safety; however, therapists also need to chip away at clients' stories by introducing the notion that their OCPs symbolise feared relational dilemmas. When they trust us more, clients will allow these inner 'hidden children' to gradually peek out so we can slowly help them contact these lost feelings and reorganise how they contact us. The trick is finding creative ways to widen or deepen the exploration. Because in OCPs the traumas are pretty dissociated, these processes are repetitive but meaningful. Through attention to the unfolding process in session, therapists can help clients make clearer links between their symptoms and their feelings in the transference (e.g. 'I think I'm feeling the urge to hand-wash right now because I'm afraid to tell you I'm angry at you').

Therapists need to be very aware of their countertransference responses around aggression (i.e. defensiveness, a need to be right or to retaliate when feeling criticised) so they can not only contain but also be alert for opportunities to repeatedly affirm,

encourage and invite a client's buried impulses to differentiate and aggress. Therapists need to be comfortable allowing clients to push them away so clients can see their therapist 'survives destruction' (Winnicott, 1971/2005, p.120). These clients are highly sensitive to confluence and if they sense the therapist's unconscious need for them to protect the therapist's ego, this can be retraumatising.

The Gestalt model of working with parts has to be done very skilfully so it does not feel blaming. Many clients with OCPs are initially unable to own that they are the creators of their own terrifying projections – their OCD terroriser – because they are so fused with their fears that they cannot access another part. Therapists need to help these clients create a comforting part (and/or borrow a sense of comfort from the therapist) before helping them recognise that they have a choice to not terrorise themselves. At the same time, some approaches wait too long, and a Gestalt approach has encouraged me to experiment more by nudging my clients on their fears (which these clients need), sensing where I can open up awareness. This is key in healing OCP, because although their feelings are deeply buried, many clients will surprisingly tolerate going deeper when safely supported.

Conclusion

If you found parts of yourself in this article, it is because understanding OCPs offers a hopeful glimpse into the more spacious ways of living that are supports for all of us. When gripped by uncertainties or painful beliefs about ourselves, we too become mentally vigilant, confining ourselves to living in the smallest room in the house. Surrendering to a sense that we are held by something greater than ourselves at these moments – 'that space which is not made of thought' (Krishnamurti, 2010) – can unwrap us from our fears and grant us access to rooms we have yet to discover.

Future studies should consider the value of phenomenological approaches to guide their research rather than rejecting what cannot be easily standardised. Researchers need to define 'trauma' more broadly, contextually, and experientially, rather than objectively, viewing OCPs as a sign that clients *felt* traumatised. I strongly believe that people who rely heavily on OCPs represent a particular temperamental archetypal conglomerate of the '*highly sensitive person*' (HSP) (Aron, 1996), the 'empath' (Orloff, 2017), and '*the highly reactive type*' (Kagan, 1997). These people have lower thresholds for feeling overwhelmed and are highly reactive to novelty and uncertainty (Kagan, 1997, p. 151), making them more prone to feeling traumatised in environments others would not find traumatising. This co-creates the obsessive field experience. Additionally, people with OCPs would benefit from a programme tailored to their own unique set of struggles.

References

Aron, E. (1996). *The Highly Sensitive Person: How to Thrive When the World Overwhelms You*. New York: Broadway Books.

Bion, W. (1977). *Seven Servants: Four Works by Wilfred R. Bion*. New York: Jason Aronson.

Doron, G., Moulding, R., Kyrios, M., Nedelijkovic, M. and Mikulciner, M. (2009). Adult attachment insecurities are related to obsessive compulsive phenomena. *Journal of Social and Clinical Psychology*, 28, pp. 1022–1049.

Francesetti, G. (2017). 'Suspended from shaky scaffolding, we secure ourselves with our fixations'. A phenomenological and Gestalt exploration of obsessive–compulsive disorder. *British Gestalt Journal*, 26(2), pp. 5–20.

Frank, R. and La Barre, F. (2011). *The First Year and the Rest of Your Life: Movement, Development and Psychotherapeutic Change*. New York: Routledge.

Freud, S. (1955). *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIII (1913-1914): Totem and Taboo and Other Works* (trans. and edited by J. Strachey). London: Hogarth Press.

Huppert, J.D., Moser, J.S., Gershuny, B.S., Riggs, D.S., Spokas, M., Filip, J., Hajcak, G., Parker, H.A., Baer, L. and Foa, E.B. (2005). The relationship between obsessive compulsive and posttraumatic stress symptoms in clinical and non-clinical samples. *Anxiety Disorders*, 19, pp. 127–136.

Jacobs, L. (2003). Being a Repeat, Repeating Being. *International Gestalt Journal*, 26(1), pp. 38–45.

Kagan, J. (1997). In the Beginning: The Contribution of Temperament to Personality Development. *Modern Psychoanalysis*, 22, pp. 145–155.

Krishnamurti, J. (2010). *J.KrishnamurtiOnline*. Available at: <http://www.jkrishnamurti.org/krishnamurti-teachings/view-daily-quote/20171203.php> (Accessed 7 March 2017).

Maltby, N. and Tolin, D.F. (2005). A brief motivational intervention for treatment-refusing OCD patients. *Cognitive Behavioral Therapy*, 34(3), pp. 176–184.

Meetings of the New York Psychoanalytic Society (1971). *Psychoanalytic Quarterly*, 40, p. 383.

Molino, A. (ed.) (1997). *Freely Associated: Encounters in Psychoanalysis with Christopher Bollas, Joyce McDougall, Michael Eigen, Adam Phillips and Nina Coltart*. New York: Free Association Books.

Ogden, P. and Fisher, J. (2015). *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment*. New York: W. W. Norton.

Orloff, J. (2017). *The Empath's Survival Guide: Life Strategies for Sensitive People*. Boulder: Sounds True.

Perls, F., Hefferline, R., and Goodman, P. (1951/2009). *Gestalt Therapy: Excitement and Growth in the Human Personality*. New York: Julian Press.

Rezvan, S., Bahramai, F., Mohamadreza, A., Macleod, C., Taher Neshat Doost, H. and Ghasemi, V. (2013). A preliminary study on the effects of attachment-based intervention on pediatric obsessive-compulsive disorder. *International Journal of Preventive Medicine*, 4(1), pp. 78–87.

Schruers, K., Koning, K., Luermans, J., Haack, M. and Griez, E. (2005). Obsessive-compulsive disorder: a critical review of therapeutic perspectives. *Acta Psychiatrica Scandinavica*, 111,

pp. 261–271. Available at: <http://dx.doi.org/10.1111/j.1600-0447.2004.00502.x> (Accessed 7 March 2017).

Stern, D.N. (1985). *The Interpersonal World of the Infant. A View from Psychchoanalysis and Developmental Psychology*. New York: Basic Books.

Winnicott, D.W. (1975). *Through paediatrics to psycho-analysis*. New York: Basic Books.

Winnicott, D.W. (1971/2005). *Playing and reality*. Abingdon: Routledge.

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