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# Call Me Irresponsible

*By Fred Penzel, PhD.*

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The other day, a new patient of mine, a woman in her thirties, arrived fifteen minutes late for her appointment all out of breath. The lateness, she announced, was due to her having misplaced a very important list, which she was still unable to locate. When I inquired as to what was on this list, she informed me that it amounted to about twenty pages of notes she had made about every possible situation she had been in, over the last seventeen years, in which she might have been negligent and caused harm to another person. These notes, she believed contained vital information about her every word and movement on each of these various days. At least everything she could recall. These situations included possible traffic accidents, insults to others, property damage, the creation of hazards for others, and what might have been some sexual acting out. A complicating factor for her was that when she tried to recreate one of these situations, she could not be sure about what she had or had not done. She would then repetitively worry that she had really done something wrong, and then become convulsed with anxiety. These concerns were what mental health practitioners would call obsessions. They might change from day-to-day, in terms of the particular incident, but all had the same theme.

Typically, when OC sufferers experience these types of thoughts, they react by performing compulsions of various kinds in order to relieve their anxiety. In my patient's case, this amounted to re-reading the particular page of her list dozens of times in an attempt to review all the events of the day on which the supposed event had happened. In this way, she believed she could reassure herself that the worst had not happened, and that she would therefore not have to feel guilty about anything. My patient believed that if she learned that she had actually harmed someone, she would feel a crushing sense of guilt she could not then live with. Either this would cause her to "go insane," or, according to her own rules, she would have to commit suicide. Because she had lost her list earlier in the day, she had spent many hours ransacking her house and car, and trying to mentally reconstruct everything she had written on her list. This, then, is a glimpse through the window of what is known as hyper-responsibility (HR).

I suppose that if you had to identify one of the chief hallmarks of OCD, it would be doubt. This is no ordinary doubt, however. This is a no-holds-barred debilitating, paralyzing doubt. It is pathological doubt, or, doubt raised to the level of an illness. When it occurs, the need to resolve it and find relief can grow to outweigh every other priority in a person's life. OC sufferers can become doubtful about anything the human mind can conceive. Although many OCD sufferers only worry about bad things happening to them, there are also many who, especially those with HR, worry about others. Exactly why certain individuals with OCD can become doubtful about having harmed others in some way remains a mystery.

In some cases of HR, we see sufferers taking on an exaggerated and unnecessary responsibility for others' health, safety, and well being. They are not just partially responsible for what occurs in their dealings with others. They are totally responsible. In addition, their sense of what they are capable of doing to others is also exaggerated. For instance if someone without HR physically bumped into someone on the street, they might be concerned for that instant that they had hurt the other person, but then seeing that everything was okay, would then go their way without giving it another thought. A HR sufferer, would immediately assume that they had

caused serious injuries, and would obsessively worry about the bump for hours or days afterward convinced that the other person had sustained hidden internal injuries that had a delayed effect and was most likely hospitalised or dead. Subsequently, they might read the papers or watch the news to see if anything had been reported. They might even call the police or the local hospitals. When driving, some HR sufferers have problems with what has become known as 'Hit-and-Run-OCD." Every bump in the road may seem to them to be a body they have driven over. Every pedestrian, child playing, or jogger at the side of the road becomes someone he or she could have struck with his or her car. Even a blur or a shadow seen out of the comer of their eye can become a potential victim. Backing out of a driveway can become an excruciating task. Driving back and forth over the same route to hunt for bodies, or getting out to repeatedly check the car for dents or bloodstains can become a routine part of every trip.

Food preparation has always been a problem for people with HR-type symptoms. The sufferer's fear is that he will act negligently and serve spoiled, contaminated, or poisoned food to guests or family members. There may be thoughts that such things as household cleaners, bits of broken glass, insecticide, drain cleaner, etc. have somehow gotten into the food they are cooking, so all food must be prepared in an absolutely meticulous way to rule out all possible accidents. Fears of botulism or salmonella may lead to repeated hand washing, smelling or scrupulous examining of the food. One patient of mine would regularly call dinner guests after they had gone home to make sure they had not gotten ill or died. Many sufferers end up not being able to prepare food at all.

Conversations with others can also be potential mine fields. Every off-handed remark made to another person may later be reviewed to see if something offensive, overly critical, or insulting was said. Repeated questions or phone calling may follow these conversations in order to find out exactly what was said, or how the other person may have regarded it.

When someone with HR also suffers from contamination phobias, their main concern is with others, not him or her. Those with HR may also find themselves in a constant state of high vigilance, continually scanning the environment for possible hazards to others. If they spot a street-fight out or see a damaged traffic sign, they will be the ones to report it. If someone's car looks like it has a tire low on air, he or she will feel compelled to leave a note under the windshield wiper. They may be seen picking up pieces of broken glass in the street, or bringing outdated packages of food to show the supermarket manager. They may even restack the canned goods on the supermarket shelves so they will not fall on anyone and injure them. It is almost as if they have been appointed as the world's guardian and protector. It can often grow to become a full-time job.

HR becomes especially unpleasant when the obsessions have sexual themes. A common one among adult sufferers is the thought that there is a possibility that they may have acted in a sexually inappropriate manner to a child. I have met numerous individuals who feared that they had made sexually suggestive remarks that could corrupt children. Or even worse, that they have touched children sexually or exposed their bodies to them in some way. Even touching a child on the shoulder or getting an innocent hug may seem to them to be filled with sexual meaning. A strenuous attempt to avoid contact with children is the inevitable result.

While we know that OCD is a chronic disorder, you can recover with the proper treatment. Treatment for this type of OCD would, of course, involve the use of Cognitive/Behavioral Therapy (CBT), and the approach would be twofold.

On the behavioral level, Exposure and Response Prevention (E&RP) would be the treatment of choice. In this type of therapy, the person with OCD rates his or her fears from least frightening to the most. With the help of a therapist, he or she gradually confronts these rituals. The goal is to build a tolerance to the anxiety and the anxiety producing thoughts and situations.

By staying with the anxiety and not avoiding, the sufferer comes to learn the truth of the matter - that the anxiety eventually subsides, and that the dreaded event never happens. Thus, working in a step-by-step way via behavioral assignments, the sufferer can eventually be able to experience the thoughts or situations and not feel that they must react in any way. Ultimately, they can achieve the ability to accept the thoughts, even though they are extremely unpleasant.

Typical E&RP assignments would revolve around having the sufferer do things that usually causes him or her doubt. At the same time the therapist needs to expose him or her to the thought that he or she definitely did something careless and that the worst has actually happened or will happen. At the same time, the person with HR is discouraged from checking, questioning, or doing rituals to prevent the harm. A person with hit-and-run fears might carry out driving assignments in increasingly challenging situations, while listening to tapes telling him that he

has run someone over. An individual with food fears could be asked to prepare meals and snacks for others, while keeping household cleaners or broken glass nearby, he would simultaneously be listening to audio exposure tapes telling him that they were poisoning or harming his loved ones. Other E&RP possibilities, depending upon the symptoms, would be to bump into others on the street, to criticise others in minor ways, to resist reporting possible public hazards, to resist calling the police or public agencies to find out whether accidents have recently occurred, ask others for reassurance or to call them to find out if they are all right, or to fight the urge to revisit and check the scenes where accidents or problems might have occurred.

On the cognitive level, sufferers are taught to challenge their beliefs about just how responsible they are for the safety and well-being of others, and in their dealings with others, what proportion of the responsibility is really theirs. The role of guilt is also examined, and a better understanding of what it is and what role it has to play with regard to people dealing rationally with real errors and mistakes. Further, the assumption that any given individual can and must be perfect and never do anything wrong or harm anyone else in any way is also challenged. In my own work, this type of therapy is brought in after the sufferer has made some progress with their behavioural work and begun to get a grip on his or her anxiety.

In my opinion medications, too, may have a role to play in treatment of HR. I think that if the sufferer is highly anxious and agitated or severely depressed, medication can prepare him or her for behavior therapy. Additionally, if obsessions are so strong and believable that an individual feels truly unable to approach behavioral assignments, medication may also have to be included in the treatment package. It is my opinion that medication should not be considered a complete treatment on its own. I also think it should, instead, be regarded as a tool to enable a person to successfully participate in therapy. Medication alone cannot teach someone suffering with CCD the new skills needed to confront the things that cause anxiety in a world full of risks that must be taken in order to live freely. Finally, it is my belief that medication cannot teach you to accept your disorder so that you can begin the process of change. With proper treatment, HR sufferers can recover and live lives as normal and average as anyone else's. It takes hard work, commitment, and determination, but recovery is there if you want it.