Purely Obsessional OCD

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Purely Obsessional Obsessive-Compulsive Disorder (also called Pure Obsessional OCD, Pure-O, OCD without overt compulsions or Primarily Obsessional OCD) is a lesser-known form or manifestation of OCD. For people with Purely Obsessional OCD, there are usually no observable compulsions, such as those commonly seen in those with the typical form of OCD (checking, counting, hand-washing, etc.). While ritualizing and neutralizing behaviors do take place, they are almost entirely in the form of excessive mental rumination.

Common themes

The nature and type of Purely Obsessional OCD varies greatly, but the central theme for all sufferers is the emergence of a disturbing intrusive thought or question, an unwanted/inappropriate mental image, or a frightening impulse that causes the person extreme anxiety because it is antithetical to closely-held religious beliefs, morals, or societal mores. While those without Purely Obsessional OCD might instinctively respond to bizarre intrusive thoughts or impulses as insignificant and part of a normal variance in the human mind, someone with Purely Obsessional OCD will respond with profound alarm followed by an intense attempt to neutralize the thought or avoid having the thought again. The person begins to ask themselves constantly "Am I really capable of something like that? or Could that really happen? or "Is that really me? (even though they usually realize that their fear is irrational, which causes them further distress) and puts tremendous effort into escaping or resolving the unwanted thought. They then end up in a vicious cycle of mentally searching for reassurance and trying to get a definitive answer.

Common intrusive thoughts/obsessions include themes of:

Responsibility: with an excessive concern over someone's well-being marked specifically by guilt over believing they have harmed or might harm (either on purpose or inadvertently) someone.
Sexuality: including recurrent doubt over one's sexual orientation (also called HOCD or "homosexual OCD"). People with this theme display a very different set of symptoms than those actually experiencing an actual crisis in sexuality. The question "Am I gay" takes on a pathological form. Many people with this type of obsession are in healthy and fulfilling romantic relationships, either with members of the opposite sex, or the same sex (in which case their fear would be "Am I straight?).
Violence: which involves a constant fear of violently harming oneself or loved ones or persistent worry that one is a pedophile and might harm a child.
Religiosity: manifesting as intrusive thoughts or impulses revolving around blasphemous and sacrilegious themes.
Health: including consistent fears of having or contracting a disease (different from hypochondriasis) through seemingly impossible means (for example, touching an object that has just been touched by someone with a disease) or mistrust of a diagnostic test.
Relationship Substantiation: in which someone in a romantic relationship endlessly tried to

ascertain the justification for being or remaining in that relationship. It includes obsessive thoughts to the tune of How do I know this is real love? How do I know he/she is the one? "Am I attracted enough to this person? or "Am I in love with this person, or is it just love? The agony of attempting to arrive at certainty leads to an intense and endless cycle of anxiety because it is impossible to arrive at a definite answer.

Diagnosis and treatment

Those suffering from Purely Obsessional OCD might appear normal and high-functioning, yet spend a great deal of time ruminating, trying to solve or answer any of the questions that cause them distress.

For example, an intrusive thought "I could just kill Bill with this steak knife" is followed by a catastrophic misinterpretation of the thought, i.e. How could I have such a thought? Deep down, I must be a psychopath." This might lead a person to continually surf the web, reading numerous articles on defining psychopathy. This reassurance-seeking ritual will, ironically, provide no further clarification and could exacerbate the intensity of the search for the answer. There are numerous corresponding cognitive biases present, including thought-action fusion, over-importance of thoughts, and need for control over thoughts.

The disorder is particularly easy to miss by many well-trained clinicians, as it closely resembles markers of generalized anxiety disorder and does not include observable, compulsive behaviors. Clinical "success" is reached when the Purely Obsessional OCD sufferer becomes indifferent to the need to answer the question. While many clinicians will mistakenly offer reassurance and try to help their patient achieve a definitive answer (an unfortunate consequence of therapists treating Purely Obsessional OCD as generalized anxiety disorder), this method only contributes to the intensity or length of the patient's rumination, as the neuropathways of the OCD brain will predictably come up with creative ways to "trick" the person out of reassurance, negating any temporary relief and perpetuating the cycle of obsessing.

The most effective treatment for Purely Obsessional OCD appears to be Cognitive-Behavioral Therapy. More specifically exposure and response prevention (ERP) as well as Cognitive Therapy (CT) which may or may not be combined with the use of medication, such as SSRIs. People suffering from OCD without overt compulsions are considered by some researchers more refractory towards ERP compared to other OCD sufferers and therefore ERP can prove less successful than CT.

Exposure and response prevention (ERP) of the "Pure-O" is theoretically based on the principles of classical conditioning and extinction. The spike often presents itself as a paramount question or disastrous scenario. A response that answers the spike in a way that leaves ambiguity is sometimes warranted. "If I don't remember what I had for breakfast yesterday my mother will die of

cancer!" Using the antidote procedure, a cognitive response would be one in which the subject accepts this possibility and is willing to take the risk of his mother dying of cancer or the question recurring for eternity. No effort is expended in directly answering the question in an effort to find resolution. In another example, the spike would be, "Maybe I said something offensive to my boss yesterday." A recommended response would be, "Maybe I did. I'll live with the possibility and take the risk he'll fire me tomorrow." Using this procedure, it is imperative that the distinction be made between the therapeutic response and rumination. The therapeutic response does not seek to answer the question but to accept the uncertainty of the unsolved dilemma.