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ANALOG CONTRACTS

or

HOW TO END AN OBSESSIVE COMPULSIVE DISORDERS

by

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In this paper, the male pronoun will apply either gender. The nominal pronoun will apply to the first author. The plural pronoun will apply to both authors.

This paper is essentially about the structure of the therapeutic algorithm to infract across an Obsessive Compulsive Disorder.
It examines the epistemology for OCD. This paper will do so with the exploration of 8 cases beginning with the case documented in the work *Advanced Techniques of Hypnosis and Therapy Selected Papers of Milton H. Erickson, M.D.*
The other 7 are from the authors records.

For us, the presentation of this paper is quite a momentous event since, for the first time, anywhere, we are sharing with you something that is new and original to the world of Psychotherapy. It is the fruit of some 5 years of research. It is how to construct a therapeutic algorithm[1] to infract across the operations of a Obsessive Compulsive Disorder.

We begin by citing what DSM-III-R[2] states about Obsessive Compulsive Disorder:

> **The essential feature of this disorder is recurrent obsessions or compulsions sufficiently severe to cause marked distress, be time-consuming, or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships with others.**
>
> **Obsessions are persistent ideas, thoughts, impulses, or images that are experienced, at least initially, as intrusive and senseless - for example, a parent having repeated impulses to kill a loved child, or a religious person having recurrent blasphemous thoughts. The person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thoughts or action. The person recognizes that the obsessions are the product of his or own mind, and are not imposed from without (as in the delusion of thought insertion).**

The most common obsessions are repetitive thoughts of violence (e.g., killing one's child), contamination (e.g., becoming infected by shaking hands), and doubt (e.g., repeatedly wondering whether one has performed some act such as having hurt someone in a traffic accident).

Compulsions **are repetitive, purposeful, and intentional behaviours that are performed in response to an obsession, according to certain rules, or in a stereotyped fashion. The behaviour is designed to neutralize or to prevent discomfort or some dreaded event or situation. However, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent, or it is clearly excessive. The act is performed with a sense of subjective compulsion that is coupled with a desire to resist the compulsion (initially). The person recognizes that his behaviour is excessive or unreasonable (this may not be true for young children and may no longer be true for people whose obsessions have evolved into overvalued ideas) and does not derive pleasure from carrying out the activity, although it provides a release of tension. The most common compulsions involve hand-washing, counting, checking and touching.**

When the person attempts to resist a compulsion, there is a sense of mounting tension that can be immediately relieved by yielding to the compulsion. In the course of the illness, after repeated failure at resisting the compulsions, the person may give in to them and no longer experience a desire to resist them.

The American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition - Revised) 1987 page 245.

For us and for this work we shall define an OCD as either an unwanted recurrent compelling thought or behaviour.

From the documented clinical work of Milton H. Erickson, M.D., we know it is possible to contrive a therapeutic algorithm that when it is applied, will end the OCD. If this is not done then the alternative is to use psychotropic drugs. We all know how sensitive and vulnerable the cerebral neurons are. To wack them with drugs in the hope that it will compel a state of "quietude" in the cluster of neurons, that one speculates is responsible for the OCD, is truly voodoo psycho-chemotherapy and highly speculative and suspect thinking in Neurology.

Case I:

This case is taken from the work, *Advanced Techniques of Hypnosis and Therapy Selected Papers by Milton H. Erickson*[3]*, M.D.,* edited by Jay Haley.

The title of the paper is Indirect Hypnotic Therapy in an Enuretic Couple. However, the reader can satisfy himself when he reads this paper that there really was no hypnotic work of any sort that was done. From our point of view, the way it was done was in fact very direct. We think the title, *Indirect Hypnotic Therapy for an Enuretic Couple*, to the paper is anomalous, since no hypnosis was done at all.

This case concerns a newly wed couple who awoke the next morning, after their wedding night, to face the problem that each, unbeknown to the other had wet the bed. '. . . each was silently and profoundly grateful to the other for the unbelievable forbearance shown in not commenting about the wet bed.' In this way each continued to bed wet, without realizing that the other also contributed to the bed wetting. This 'continued to be manifested each morning for nine months' The result was that there '. . . was an ever-increasing feeling of love and regard for each other because of the sympathetic silence shown.'

However, eventually they discovered that the other also wet the bed. It was with this discovery that they sought help and eventually came to Milton H. Erickson, M.D.

Milton H. Erickson was to treat this case by requiring each to do something each night before they went to bed. In our work, we now name such a manoeuver of therapy as an **analog contract**[4]. It is so named as the patient is required to carry out what is prescribed. Since what is prescribed is a behavioural action, the contract is, therefore, an analogical one, hence the name, an analog contract. In this instance this was the analog contract.

> **"This is what you are to do: Each evening you are to take fluids freely. Two hours before you go to bed, lock the bathroom door after drinking a glass of water. At bedtime get into your pyjamas and then kneel side by side on the bed, facing your pillows and deliberately, intentionally and jointly wet the bed. This may be hard to do, but you must do it. Then lie down and go to sleep, knowing full well that the wetting of the bed is over and done with for the night, that nothing can really make it noticeably wetter."**
>
> **Do this every night, no matter how much you hate it - you have promised though you did not know what the promise entailed, but you are obligated. Do it every night for two weeks, that is, until Sunday the 17th. On Sunday night, you may take a rest from this task. You may that night lie down and go to sleep in a dry bed.**
>
> **"On Monday morning, the 18th, you will arise, throw back the covers, look at the bed. Only as you see a wet bed, then and only then will you realize that there will be before you another three weeks of kneeling and wetting the bed.**
>
> **"You have your instructions. There is to be no discussion and no**

debating between you about this, just silence. There is to be only obedience, and you will then give me a full and amazing account. Goodby!"

Jay Haley, Editor: *Indirect Hypnotic Therapy of an Enuretic Couple*. *Advanced Techniques of Hypnosis and Therapy Indirect Hypnotic* Selected Papers of Milton H. Erickson, M.D. Grune and Stratton 1967 page 410 - 421

Of course the analog contract was successful in ending the problem. We now know that the way of resolving Obsessive Compulsive Disorder is by the creation and the application of an Analog Contract. It is only in the doing or action that the implicate structure of the Obsessive Compulsive Disorder can be deleted.

Conventionally, nocturnal enuresis would not be regarded as Obsessive Compulsive Behaviour. Yet in this case, we do classify it as such.

It is for this that you would have to wonder how you would classify these relatively more common conditions, uncontrolled gambling, alcoholism, smoking, nail biting and cheek chewing. We are of the view that they be classified as OCDs.

Case II:

A lady came to see us with a most distressing story. She had 5 children. As they were growing up into their adulthood she and her husband decided to adopt a child. She and her husband loved this child. She was to grow up to be a beautiful girl.

It was then a matter of great distress that their daughter left home to live in a common-law relationship. She came from that generation in which such thing was never done.

It was to be worse when her daughter and her common-law husband came to live in a newly built townhouse opposite to hers. Now, the offending way of life afflicting her daughter was brought to her door step.

That very first summer, she heard her daughter screaming from across the road. It was clear that the man was beating her daughter. She immediately ran across to help. The door was not locked and she just rushed into the house.

When her daughter and her man saw her, they closed ranks and demanded she leave their home at once. Shocked and confused she retreated home, feeling some embarrassment and humiliation. When she got home she put the kettle on for some comforting tea to drink. She was just about to do so when the front door bell ran. When she opened it, there stood a police officer. He had come on the matter of a complaint about trespassing on the property of the owners opposite to her!

Thereafter, she could not stop looking across the road at her daughter's home. If she had to shop, it was done as expeditiously as possible so that she could come home and stand by the window and keep looking out at her daughter's place. She resented anything that took her away from her

place by the window, activities as cooking for her husband or ironing the laundry and so forth.

This then was her OCD.

For us, it was clear that the implicate structure[5] driving her OCD was her overwhelming concern for her daughter's welfare. Since there was a ban on her going over, the only thing she could do to be sure that her daughter was all right was to stand by the window to keep a constant eye on things.

We now will cite the analog contract that redressed her problem. The structure of the analog contract offered her the choice to continue to do what she felt compelled to do or face the utter and intolerable idiocy of her OCD. The answer was to place a full length mirror near where she stood by the window so that as she looked out at her daughters place she could also see herself looking out.

In less than 48 hours she rang my office to ask my secretary to tell me that she had stopped her OCD.

Case III

We classify nail biting as an OCD. It is, in one sense, the condition that is the *par excellence* for such a diagnosis.

We have an analog contract that when it is applied and the patient congruently consents to carry it out, by the end of three days the OCD will end.

What do you think would be the Analog contract that is used. We can tell you . However, we think it would be singularly satisfying if you think through, on the implied basis that the answer exists in what we have already written for you.

Case IV

Tricholomania is a singularly stubborn problem. For this, also there is an Analog Contract. However, the contract has to be most firmly and seriously entered into. The contract is to apply for 7 days with a clear understanding that it will apply for another 7 days if the first 7 days has not remitted the condition.

For the same consideration we invite you to determine how you would end the OCD of the tricholomanic.

Case V:

This case is of a young woman who always had to turn her head to look and check if she had hit a person that she had driven past. In many a case, in fact she turned her car around and drove back to check if she had hit the person.

To close enquiry it is very clear that the implicate structure for this OCD is <u>concern in physically injuring another</u>. This implicate structure is so compelling that she cannot be too sure that

she might not have hit and injured another. Therefore, she has to check.

What is the analog contract that you might construct to discount this implicate structure?

Case VII:

This case concerns a young woman who presented with Vaginismus. At some time in her life, she had developed a soreness in her hands. She then concluded that it was because of an infection. Therefore, by washing and cleaning, she would wash the germs away and she would not become infected.

In time, this deviant belief overlapped into an deep concern that the germ from her faeces would get into her vagina. It was now imperative that she wash and be clean in her perineal area, especially her genital zone. She pursued this with such diligence that she excoriated the area.

It is very clear that in this case, the implicate structure for the OCD is an anomalous belief that the condition of her vagina is vulnerable to the bacteria from her anus. So, what is the kind of analog contract that you would devise to infract across such an implicate structure?

Case VIII:

This is the case of a 4 year old girl who had a need to wash and clean her hands until they were red and excoriated.

Jennifer agreed that she was to continue to do so and certainly as diligently as she ever did. However at the end of each wash, she was to apply hand cream to her hands.

She stopped her hand washing in three days.

STRUCTURE OF THE ALGORITHM:

We propose these steps for the construction and successful application of an algorithm for an OCD:

1. You are to be sure what is the pattern of the OCD.
2. The algorithm requires you to use the patterned behaviour.
3. However, it is to be used in a context and at a frequency that you are to specify. The context is so created that it requires the person to go meta to what he is doing.
4. Finally, and this is the most important of all - the details of the algorithm cannot be revealed to the patient until the patient agrees in the most solemn of ways that he will carry it out. If you do not get this solemn promise, a patient, in not carrying out what is indexed, will vitiate the efficacy of the algorithmn.

Finally, for those of you who wish to credit us for the information we have shared with you, we hope you will allow us to name this manouvre of the therapy as the:

This is possible to do since, neither Milton H. Erickson, M.D. nor Jay Haley worked out the structure for the algorithm. For us it has been such an exciting work it out.

Endnotes:

1. **Therapeutic algorithm** is a recipe of steps for a desired state by undoing a problem state. The first and perhaps the most famous of such algorithms is the one invented for Flying Phobia. It was originally a piece of work that extended took an hour to do and the result was evinced at the end. In time the work was so refined that it only needed 6 minutes to do and at the end the outcome was secured.

OCDs as behavioural totes are more complex. Yet our algorithm only takes less than 10 sentences to utter. It will take three days, however, to evince the outcome.

2. **DSM-III-R** is the immediate predecessor of DSM IV. Clearly the description of Obsessive Compulsive Disorder from DSM-III-R has no significant difference from the newer version of this work.

3. **DSM-III-R** is the immediate predecessor of DSM IV. Clearly the description of Obsessive Compulsive Disorder from DSM-III-R has no significant difference from the newer version of this work.

4. **Analog Contract**

When you have creatively determined the form of the Analog Contract, you will then have to apply it. It is very clear that when Milton H. Erickson applied his analog contract it was done with appropriate gravity. It seemed as if he wanted a full commitment from the patient that they would carry it out before he told them what the prescription of treatment was. We share fully with him that this is the way to apply the contract. We do so because the semantic form of the analog contract may be of such nature that the patient is likely to take the attitude, “This is too silly for words to do. I am NOT going to do it.”

It is also a requisite in the form of the analog contract that you accept the OCD as a part of the contract.

5. **Implicate Structure**

This is a concept that has been introduced into the therapies as a way of guiding an operator to look for the variable that is determining a problem state to exist.

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