When Automatic Bodily Processes Become Conscious: How to Disengage from “Sensorimotor Obsessions”

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The literature on obsessive-compulsive disorder (OCD) routinely includes detailed accounts of washing, checking, repeating, and undoing behaviors associated with fears of harm to oneself or others. Likewise, descriptions of intrusive sexual or violent imagery; urges to touch, tap, or even-up objects; and concerns about good and bad, right and wrong, populate the pages of scientific and self-help books and articles on OCD. Yet for some individuals suffering from obsessive-compulsive disorder, there is little hope of “finding themselves” in the pages of this popular literature. Their OCD is somehow different: it simply does not conform to these popular descriptions.

One such neglected subgroup of sufferers report distressing preoccupations with bodily processes or bodily sensations. Colloquially termed “obsessive swallowing,” “obsessive blinking,” or “conscious breathing,” these problems fall within a class of complaints that may be aptly described as “sensorimotor obsessions”. Sensorimotor obsessions as defined here involve either a focus on automatic bodily processes or discrete physical sensations. Whether technically sensory or sensorimotor in nature, such obsessions share one common precursor: selective attention. Any bodily process or sensation to which one selectively attends can form the foundation of this sensory or sensorimotor obsession. In a typical scenario, individuals begin to selectively attend to their swallowing, for example, and become anxious that they will become unable to stop thinking about their swallowing. Attempts to distract themselves fail, leading to higher levels of anxiety. This anxiety perpetuates the focus on swallowing, leaving them preoccupied and frustrated by their unsuccessful attempts to shift attention elsewhere.

Examples of Common Sensorimotor Obsessions

Sensorimotor obsessions often involve one or more of the following:

- **breathing** [whether breathing is shallow or deep, or the focus is on some other sensation of breathing]
- **blinking** [how often one blinks or the physical requirement to blink]
- **swallowing/salivation** [how frequently one swallows, the amount of salivation produced, or the sensation of swallowing itself]
- **movement of the mouth and/or tongue during speech**
- **pulse/heartbeat** [awareness of pulse or heartbeat, particularly at night while trying to fall asleep]
- **eye contact** [unlike social anxiety-based concerns, this form involves awareness of the eye contact itself or which eye one is looking at when staring into the eyes of another person]

- **visual distractions** [e.g. paying attention to “floaters”, the particulate matter that is drifting within the eye that is most visible when staring at a blank wall or awareness of subtle movements of the eyes, such as saccadic eye movements]

- **awareness of specific body parts** [e.g. perception of the side of one’s nose while trying to read or, as in the cases of a young boy and older man, a hyper-awareness of particular body parts such as their feet or fingers respectively]

**Distinguishing Characteristics**

Sensorimotor obsessions as defined here rarely involve elaborated fears of harm to oneself or others. Fears center mainly on the concern that automatic bodily processes or physical sensations will fail to return to their previous unconscious state, thus forever “driving the sufferer crazy.” Such fears are frequently accompanied by the broader concern that the obsession itself will be unending, a concern that Dr. Jonathan Grayson has termed “obsessing about obsessing” (Grayson, 2004). Sensorimotor obsessions are infrequently accompanied by perfectionistic attitudes or beliefs; however, they do occasionally play a role, as in the case of a perfectionistic patient who was constantly preoccupied by smudges on his glasses and by other imperfections in his sensory environment. By definition sufferers report significant levels of distress, particularly as a result of impairments in concentration at work, when socializing, or when attempting to fall asleep. Compulsions in response to sensorimotor obsessions are usually limited to repeated attempts to use distraction to interrupt the fixation on sensory phenomena.

Most people at some point in their lives have experienced transient problems with this sort of sensory hyper-awareness. Stuffy noses, irritated eyes, rashes, coughing and the like represent the normal sensory annoyances that can come to preoccupy individuals for short periods of time. For some less fortunate individuals, their chronic allergies, pain syndromes, and other medical problems cause sustained interruptions to selective attention. However, for a minority of sufferers, their awareness of sensorimotor phenomena *elicits anxiety and preoccupation* severe enough to warrant a clinical diagnosis of obsessive-compulsive disorder or an obsessive-compulsive spectrum condition.

**Relationship of Sensorimotor Obsessions to Obsessive-Compulsive Spectrum Conditions**

Anecdotal evidence suggests that sufferers diagnosed with this type of sensorimotor OCD are also more likely to have current or past difficulties with other, more common variants of obsessive-compulsive disorder, generalized anxiety disorder, or panic disorder. This reflects the fact that problems with sensory hyper-awareness are not confined to a particular diagnostic entity (such as OCD), but cut across a number of obsessive-compulsive spectrum conditions. For example individuals with bowel or bladder preoccupations, hypochondriasis, and panic disorder report not only sensory hyper-awareness (such as fullness of the bladder, acute physical symptoms, or rapid
heart rate) but also cognitive embellishments that involve specific, catastrophic fears (such as humiliating bowel accidents, serious illness, or having a heart attack).

Currently, individuals who suffer from the relatively unelaborated sensorimotor preoccupations as described in this article are routinely diagnosed with obsessive-compulsive disorder. Individuals who suffer from elaborated catastrophic fears associated with their sensorimotor preoccupations tend to be diagnosed according to the content of those fears (e.g. a focus on heart rate that leads to fears of a heart attack is diagnosed as panic disorder). Future research will ultimately determine whether sensorimotor preoccupations that occur within various clinical diagnostic categories reflect the same or unrelated neurobiological processes.

Treatment of Sensory Obsessions

Sensory obsessions can be treated quite successfully by decoupling any sensory awareness with reactive anxiety. In other words, sufferers must ultimately experience their sensory hyperawareness without any resulting anxiety. Anxiety, as is the case in other forms of obsessive-compulsive disorder, serves as the glue that binds particular thoughts to conscious awareness. Once a thought is linked with anxiety, the conscious mind keeps it ever present. This occurs because anxiety is part of the brain’s alarm system for danger. The mind clearly does not want us to forget about any danger that may be lurking around. If a particular idea scares us, we tend to think about it over and over. In sensory obsessions, sufferers repeatedly attempt to shift their attention for fear that their sensory focus will become “stuck” and they will not be able to concentrate fully on the task at hand. Here, the thought that “I’m never going to stop thinking about this” leads to immediate fears of impaired functioning. As a result of the pairing between this thought and a feared outcome, the mind holds on tightly to the very awareness that the sufferer is attempting to rid. In many ways this is much like “white bear syndrome,” where attempts by individuals to think about anything other than a white bear lead to many more thoughts of white bears (Wegner, 1989).

In order to disengage from sensory obsessions, sufferers must learn “the art of self-awareness.” Sufferers must learn how to invite in the sensory awareness with a relaxed and accepting posture, very much like the focus on diaphragmatic breathing during mediation.

Psychoeducation

The first stage of treatment focuses on teaching patients that selective attention to previously automatic or unconscious bodily processes or sensations is not dangerous in and of itself. Patients are reassured that once their anxiety dissipates, the sensory awareness will shift. This reassurance often sets the stage for “inviting in” the sensations as a means of reducing anxiety.

Exposure and Response Prevention

In short, sensory obsessions can be outsmarted by voluntarily paying attention to the relevant bodily process or sensation. Patients are instructed to allow the sensation to be present and to invite in any such awareness (exposure) with a casual, dispassionate focus. By purposely focusing on the sensations (exposure), patients stop relying on distraction (response prevention) as the tool for reducing anxiety. Repeated voluntary exposure to the sensations leads to diminished anxiety.
as patients grow accustomed to embracing any awareness without attempts to avoid or escape it. Imaginal exposure to particular feared outcomes (e.g. “my life will be ruined,” “I’ll never have peace of mind,” “I’ll never be able to get rid of this problem,” or “this obsession will never go way”) may be employed to enhance exposure. Additionally, patients may be asked to invite in the sensations and accompanying fears throughout the day. This is accomplished by having patients place reminders (such as Post-It notes or stickers) at home, in the car, and at work. These reminders help to cue patients to engage in repeated exposures throughout the day, thus increasing the likelihood of successful habituation.

Body Scan and Mindfulness

Patients are frequently unaware of the changes in perception that occur when selectively attending to their bodies. These changes in awareness can be frightening, as they may represent an uncomfortable and disquieting level of awareness to previously unconscious bodily processes. Patients tend to believe that they must purposely shift attention away from these unusual or previously unnoticed sensations in order to restore them to their unconscious state. Participation in a body scan can help patients fluidly move in and out of their awareness of these sensations without resorting to forced attempts.

A body scan involves shifting attention to various bodily processes or sensations for prescribed periods of time. Patients are instructed to close their eyes and selectively attend to their feet, for example, until they acquire full sensory awareness. Once this occurs, they can next move to their calves, stomach, upper body, arms, head, or any particular sensorimotor process (such as breathing). Patients learn that they can move gently from one sensation to another without getting “stuck” by focusing and refocusing in the absence of anxiety, apprehension, or active attempts to force a shifting in awareness.

Mindfulness, the art of paying close attention to an experience in the absence of criticism, judgment, or defensiveness, can also play an important role. As stated earlier, eastern meditative practices in mindfulness often involve choosing certain bodily processes to be the focus of meditative practice (e.g. breathing, the rise and fall of the chest or stomach, sensations of air through the nostrils). Patients are instructed to allow their particular sensory preoccupation to become their meditative focus; they are to accept all sensations without criticism or judgment, and observe any sensations with curiosity and interest. Over time patients begin to experience a fading of sensory awareness (or much greater tolerance of it) as their anxiety diminishes and their willingness to invite in the sensations grows.

Conclusion

Sensorimotor obsessions likely affect countless thousands of individuals each year. Future research is necessary to determine how prevalent the problem is and how best to treat it. Until such systematic research is conducted, we are left with case studies and anecdotal evidence that suggests that sensorimotor obsessions are best dealt with within a cognitive-behavioral framework. Psychoeducation, cognitive reframing, reassurance, exposure and response prevention, and certain mindfulness and acceptance techniques can all play important roles in diminishing the frustration and distress associated with this maddening and at times incapacitating experience.
References


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