

DAVID ADAM

THE
MAN WHO
COULDN'T
STOP

THE TRUTH ABOUT OCD

PICADOR



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For those who deserve an explanation

*Watch your thoughts, for they become words.
Watch your words, for they become actions.
Watch your actions, for they become habits.
Watch your habits, for they become character.
Watch your character, for it becomes your destiny.*

Unknown

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ONE

Our siege mentality

An Ethiopian schoolgirl called Bira once ate a wall of her house. She didn't want to, but she found that to eat the wall was the only way to stop her thinking about it. She didn't want to think about the wall either, in fact she was greatly disturbed by the ideas and images of it that dominated her mind. The only way she could make the thoughts of the wall go away, and calm the anxiety they caused, was to follow a strange and unbearably strong urge to eat it. So she did; day after day, for year after year. By the time she was 17 years old she had eaten eight square metres of the wall – more than half a tonne of mud bricks.

Bira lived in the capital city, Addis Ababa. Her father died when she was young and she grew up with her mother. Bira had eaten mud every day for as long as she could remember, since she was a little girl. It became worse as a teenager, when she started to take it only from the wall of her home. As she did so, the images and thoughts came more vividly and more often, which only intensified her need to eat to find relief. The mud made Bira constipated

and gave her severe stomach aches. Ethiopian traditional healers tried to treat her with prayers and holy water and advised her simply to stop eating the mud. But she couldn't. She couldn't stop her thoughts about the wall, and so she couldn't stop eating it.

One day, Bira couldn't cope any more. Her distended stomach throbbed with pain and her abdomen was tight with cramp. Her throat was scratched raw from the straw in the bricks and her body riddled with parasites from the soil. In tears, she walked to her local hospital. At the time, Ethiopia had eight psychiatrists for a nation of 70 million people. Bira was fortunate. She managed to see one of them. She told him that she needed help. She knew her thoughts were wrong, but she knew she couldn't stop them alone.

An average person can have four thousand thoughts a day, and not all of them are useful or rational. Mental flotsam comes in many forms. There are the irrelevant words, phrases, names and images that flash unprompted into our minds, often as we perform some mundane task. There are earworms: tunes that wedge themselves in our heads, more prosaically called stuck-song syndrome. And there are negative thoughts – 'I cannot do this,' 'I must quit' – the sworn enemy of sports psychologists everywhere.

Then there are the very strange thoughts: those occasional, random and unprompted ideas that seem to emerge from nowhere and stun because they are vile, immoral, disgusting, sickening – and just plain weird. The seductive

question, 'what if'? What if I was to jump in front of that bus? What if I was to punch that woman?

These kinds of thoughts are more common than most people realize. Ask around. A friend of mine has a need to check the toilet bowl for rats before he sits. Another unplugs the iron and places it in an unusual place when he finishes with it, so he knows for certain the answer when his mind demands later: are you sure, really sure, that you turned it off? One tortured soul spent an evening unable to ignore the repetitive thought that he may have scrawled across an application form for his dream job the word cunt. Most people have these kinds of strange thoughts. Most shake them off. Some people don't.

When we cannot make our strange thoughts go away they can lead to misery and mental illness. The friends I mention above did not convert their strange thoughts in this way. But I did.

I turned mine into obsessive-compulsive disorder.

The day that the Brazilian racing driver Ayrton Senna died in a crash during a Grand Prix in Italy, I was stuck in the toilet of a Manchester swimming pool. The door was open but my thoughts blocked the way out.

It was May 1994. I was 22 and hungry. After swimming a few lengths of the pool, I lifted myself from the water and headed for the locker rooms. Down the steps – one, two, three – ouch! I had scraped the back of my heel down the sharp edge of the final step. It left a small graze, through which blood bulged into a blob that hung from my broken

skin. I transferred the drop to my finger and a second swelled to take its place. I pulled a paper towel from above the sink to press to my wet heel. The blood on my finger ran with the water as it dripped down my arm. My eyes, of course, followed the blood. And the anxiety, of course, rushed back, ahead even of the memory. My shoulders sagged. My stomach tightened. It had been four weeks since the incident at the bus stop, and, as much as I told myself that it no longer bothered me, I was lying.

I had pricked my finger on a screw that stuck out from the bus shelter's corrugated metal. It was a busy Saturday afternoon and there had been lots of people around. Any one of them, I thought, could easily have injured themselves in the way I had. What if one had been HIV-positive? They could have left infected blood on the screw, which then pierced my skin. That would put the virus into my bloodstream. Oh, I knew the official line was that transmission that way was impossible. The virus couldn't survive outside the body. But I also knew that, when pressed for long enough, those in the know would weaken that to virtually impossible. They couldn't be absolutely sure. In fact, several had admitted to me there was a theoretical risk.

Stood quietly in the toilets of the changing rooms, still dripping wet, my swimming goggles in one hand and the blood-stained paper towel in the other, I ran through the sequence of events at the bus stop once again. I told myself how there hadn't been any blood on the screw when I had checked it, or at least I didn't think there had been. Oh, why hadn't I made absolutely sure?

Someone else banged through the door into the swimming pool changing rooms. They whistled. I looked at my finger. Wait a minute. WHAT THE HELL HAD I DONE? I had put a paper towel on a fresh cut. OH JESUS CHRIST. There could have been anything on that paper towel. YOU STUPID BASTARD. I looked at the paper towel, now soggy. THERE IS BLOOD ON IT. Well, of course, it's my blood. HOW CAN YOU BE SURE? Someone with Aids and a bleeding hand could have touched it before me. OH JESUS. I threw it into the bin, pulled a second from the dispenser and inspected it. No blood. That helped, a little. No blood on the next one either. BUT THEY COULD HAVE DONE. I pulled the original paper towel back from the bin. It was bloody. IF THIS IS SOMEONE ELSE'S BLOOD THEN WHY ARE YOU PICKING IT UP? I quickly washed my hands. AND WHAT IF THEY BLEED INTO THE SINK TOO? DON'T TOUCH YOUR FUCKING HEEL. DON'T TOUCH YOUR FUCKING HEEL. No chance of that. WHAT IF THAT ISN'T EVEN THE PAPER TOWEL YOU THREW IN THE BIN? It could be someone else's paper towel that I was handling, someone else's blood. I looked in the bin. I couldn't see any other paper towels with blood on them. WHAT ABOUT THAT ONE?

The whistling man was ready to swim. He came to the sink, grabbed a paper towel, blew his nose and threw it into the bin. I did the same. He looked at me. I smiled. He didn't. He walked away. I didn't. He finished his swim and left. I couldn't.

Cycling home later, I was pleased with the solution I

had found. I was getting somewhere! I heard the birds and felt the spring sunshine on my face. Well, of course I couldn't have caught Aids from scratching myself on the screw at the bus stop. That was ridiculous, I could see that now. I had nothing to worry about on that score. I pulled my swimming trunks from my bag and placed them on my bedroom radiator. I rummaged in the wardrobe for my winter gloves and put them on to unfold my swimming towel and carefully retrieve the damp and blood-stained paper towel wrapped inside. I placed it on the radiator next to the trunks. It would take about ten minutes, I guessed, before it would be dry enough to check properly. Then I reached back into the bag and found the other crumpled paper towels, the ones I had lifted from the bin, and laid those out on my desk. I would check those as well, check them properly (impossible in the changing rooms), and then surely that would be that. Then I could put all this behind me. Phew! I took off the gloves and turned on the TV. The Grand Prix was about to start.

Those are my strange thoughts. That is my obsessive-compulsive disorder. I obsess about ways that I could catch Aids. I compulsively check to make sure I haven't caught HIV and I steer my behaviour to make sure I don't catch it in future. I see HIV everywhere. It lurks on toothbrushes and towels, taps and telephones. I wipe cups and bottles, hate sharing drinks and cover every scrape and graze with multiple plasters. My compulsions can demand that after a scratch from a rusty nail or a piece of glass, I return to

wrap it in absorbent paper and check for drops of contaminated blood that may have been there. Dry skin between my toes can force me to walk on my heels through crowded locker rooms, in case of blood on the floor. I have checked train seats for syringes and toilet seats for just about everything.

As a journalist, I meet a lot of people and shake their hands. If I have a cut on my finger, or I notice that someone who I talk to has a bandage or a plaster over a wound, thoughts of the handshake and how to avoid it can start to crowd out everything else. My rational self knows that these fears are ridiculous. I know that I can't catch Aids in those situations. But still the thoughts and the anxiety come.

The psychiatrist who Bira saw in Addis Ababa told her she had obsessive-compulsive disorder (OCD) too. She had persistent thoughts that were inappropriate. She could not ignore or suppress these thoughts, which made her anxious. To reduce and prevent this anxiety she developed compulsive behaviour. The compulsions fuelled the obsessions. Together, the obsessions and compulsions took up so much time and caused such distress that they disrupted her life.

Most people have heard of OCD but there is much confusion about the condition. It's commonly seen as a behavioural quirk. In fact, OCD is a severe and crippling illness, and one defined as much by the mental torment of recurring strange thoughts as physical actions such as repeated hand-washing. Bira was diagnosed with moderately-severe OCD. Yes, a girl who ate an entire wall of her house was thought

to have it only *moderately*-severe. There are plenty of people out there who have it worse. Bira spent about two hours a day thinking about the wall and eating mud. Yet, on average, OCD patients can waste up to six hours a day on their obsessions and four hours on their compulsions. A Brazilian man called Marcus had OCD that centred on obsessive thoughts about the shape of his eye-sockets, so much so that he was compelled to touch them constantly with his fingers. Marcus prodded himself blind.

It is hard to communicate obsession – severe, clinical obsession, a true monopoly of thought. Just as the human brain struggles to comprehend the magnitude of geological time, or the speed at which electronics can operate, or even the number of times a second the wings of a hummingbird can beat, so it can seem incredible that a single notion, a unique concept, can truly dominate someone's mind for days, weeks, months, years. Here is the best description I have.

Consider a personal computer, and the various windows and separate operations that the machine can run concurrently. As I write this, there is another window open in the background that updates my email, and a separate web browser that, right now, tracks football scores. When I choose, I can toggle between these windows, make them bigger or smaller, open and close others as I see fit. That is how the mind usually handles thoughts. It shares conscious concentration between tasks, while the subconscious changes the content of each window, or draws our attention among them.

Obsession is a large window that cannot be made to shrink, move or close. Even when other tasks come to the front of the mind, the obsession window is there in the background. It grinds away and is ready to sequester attention. It acts as a constant drag on the battery and degrades the performance of other tasks. And after a while it just gets really frustrating. You can't force quit and you can't turn the machine off and on. Whenever you are awake, the window is there. And when you do manage to turn your attention elsewhere, you are aware that you deliberately do so. Soon enough, the obsession will reclaim the focus. Sometimes, usually when you wake, it is absent. The screen is blank. But push a key, move the mouse, engage the brain, and it whirrs and clicks back into place.

As recently as the 1980s, psychiatrists thought that clinical obsessions and compulsions were extremely rare. They believe now that between 2 per cent and 3 per cent of people suffer from OCD at some point in their life. That means more than a million people in Britain are affected directly, and five million more in the United States. OCD is the fourth most common mental disorder after the big three – depression, substance abuse and anxiety. OCD is twice as common as autism and schizophrenia. The World Health Organization has ranked OCD as the tenth most disabling medical condition. Its impact on quality of life has been judged more severe than diabetes. But people with OCD typically wait a decade or more before they seek help.

OCD affects men and women equally. It begins usually in early teens or late adolescence and early adulthood,

though its effects can last a lifetime. It respects no cultural, ethnic, racial or geographical boundaries. OCD is a social handicap and a societal burden. Children with OCD are more likely to want friends, but less likely to make them. Adults with OCD are more likely to be unemployed and unmarried. They drag down their families. They are more likely to live with their parents. They are more likely to be celibate. If they do marry, they are less likely to have children. They are more likely to divorce. Yet many front-line doctors still fail to recognize the signs and symptoms of OCD or their significance. Few people with OCD spontaneously recover, yet two-thirds of sufferers never see a mental health professional.

The word 'obsess' first appeared in English in the early 1500s. Drawn from the Latin *obsidere*, literally 'before to sit' but more commonly defined as 'to besiege', the term has a military background. To obsess a city was to surround but not yet control it. The related *possidere*, from which we derive possess and possessed, described the subsequent stage, when a victorious army would take control of the city and conquer its people.

The drift of these words to describe troubled individuals, first in religious terms and later in clinical language, carried the same distinction. The original use of obsess reflected the belief that the strange thought – in those days attributed to an evil spirit – originated outside the victim. To be obsessed was something that happened *to* someone; a person was not obsessed with an idea – it was the idea that

obsessed them. This was different from someone who was possessed, when the spirit was thought to invade and control a person from the inside.

A diagnosis of whether someone was obsessed or possessed by evil spirits often came down to whether the victim was aware of the malevolent presence; whether they recognized their thoughts as alien and so tried to resist them. Those who were obsessed were considered able to do this. Victims of possession, because they had surrendered their soul to the invading demons, were not. They remained unaware of what was happening. The distinction survives to this day. A diagnosis of OCD usually requires a degree of what psychiatrists call insight – an obsessed person must identify the strange thoughts that drive the obsession as foreign and distressing and must make efforts to reject them.

Today, obsession is a more widely used word. Because thoughts usually come and go, the head a constant swirl of involuntary emotions and sensations, it takes only a drag of coalescence of this mental stardust around a recurrent theme to form a temporary lump, a sticking point, that society calls an obsession. In this way, people say they are obsessed when they cannot get an attractive person out of their minds, or when they cannot quell thoughts about a certain food. Our minds are so fluid that any sluggish current draws our attention. We say we obsess about sport, sex, shoes, cream buns, cars and a thousand other pleasures, sometimes all at the same time. But in time, often no time at all, these so-called obsessions break away and are carried off and consumed by the mental stream. That is not the

obsession we will talk about here. It would not make somebody eat a wall.

The obsessive thoughts of OCD are different and tend to cluster around a limited number of themes. Obsessions of contamination with dirt and disease are the most frequent and feature in about a third of cases. Irrational fears of harm – did I lock the back door? Is the oven switched off? – are the next most common, and affect about a quarter of people with OCD. About one in ten wrestles with an obsessive need for patterns and symmetry. Rarer, but still significant, are obsessions with the body and physical symptoms, religious and blasphemous thoughts, unwanted sexual thoughts, and thoughts of carrying out acts of violence. It's because obsessive thoughts are so often within these taboo and embarrassing subjects that so many people with OCD choose to hide them.

Obsession has no regard for rational explanation. No pathology of thought can be solved with more thought. The brilliant twentieth-century mathematician Kurt Gödel, a friend and colleague of Albert Einstein, lived his life for rationality. His incompleteness theorem used logic to explore and expose the limits of logic. Yet Gödel suffered from the wildly irrational and obsessive idea that he would accidentally be poisoned, from tainted food perhaps, or by gas that escaped from his refrigerator. He would eat no meal that his wife did not taste first. When she became ill and could not do this for him, the obsessive siege on his mind made Gödel starve himself to death.

*

Why I am writing this book? Obsession encourages attention to turn inward and drains focus from relationships with others. OCD cements the presence of an individual at the centre of their mind and their actions. And it distracts. There is always something else that you would rather think about, or not think about. I don't want to be selfish any more. I now have two children who need me. I don't want them to go through what I did. I don't want them to develop obsessions, to be held hostage by their strange thoughts, to think up a monster. And if they do, I want to be able to help them.

The best way to do that, I believe, is to investigate these strange and obsessive thoughts, to see how they work, where they come from and what we can learn from them. To question how the brain, our closest ally and biggest asset in millions of years of evolution, can turn against us so. To see what forces to the surface the obsessive Mr Hyde who lies dormant inside every Dr Jekyll – inside you – and how his betrayal can be stopped. And, as it turns out, it is a terrific story.

Strange thoughts, the seeds of obsession, are everywhere. They scatter across the population. Yet only occasionally do they take root. The first step in our journey to understand obsession is to see how this happens.