Observing Small and Big Traumas Contributing to Obsessive-Compulsive Behaviors: A Descriptive Qualitative Study

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Abstract

Obsessive-Compulsive Disorder (OCD) is a complex and chronic psychological condition characterized by intrusive, unwanted thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) that temporarily reduce anxiety or prevent perceived harm. Although OCD has historically been interpreted through neurobiological and cognitive-behavioral frameworks, a growing body of peer-reviewed research over the past five years suggests that trauma—both **chronic relational ("small t")** and **acute catastrophic ("big T")**—plays an important role in symptom development and persistence.

This descriptive qualitative study explored how adults diagnosed with OCD narrate and interpret the influence of trauma in shaping their symptoms. Fifteen adults aged 18–40, referred for counselling with primary OCD diagnoses, participated in semi-structured interviews that elicited life experiences, trauma histories, and meanings attached to compulsive behaviors. Thematic analysis revealed two central trauma-linked profiles: (1) **Relational or developmental traumas**—such as chronic invalidation, emotional neglect, or relational betrayal—were associated with compulsive checking, reassurance-seeking, and perfectionism-based rituals; and (2) **Acute or catastrophic traumas**—such as abuse, bereavement, and exposure to violence—were linked to contamination fears, intrusive obsessions, and repetitive cleaning or avoidance behaviors. Across cases, participants described compulsions as protective mechanisms aimed at restoring a sense of control and reducing distress.

The findings underscore the importance of **trauma-informed counselling approaches** that integrate emotional safety, regulation, and meaning-making into standard OCD interventions. This study contributes to counselling psychology by foregrounding clients' lived experiences and narrative constructions of trauma and OCD.

Keywords: trauma, obsessive-compulsive disorder, counselling psychology, qualitative research, trauma-informed care

Observing Small and Big Traumas Contributing to Obsessive-Compulsive Behaviors: A Descriptive Qualitative Study

Obsessive-Compulsive Disorder (OCD) is a debilitating psychiatric condition defined by the interplay between intrusive, anxiety-provoking obsessions and repetitive, ritualistic behaviors or mental acts (Senter et al., 2021). Symptoms frequently interfere with social, occupational, and emotional functioning, and lifetime prevalence rates hover around 2–3 % worldwide (Stein et al., 2024). While traditional models have framed OCD primarily through **cognitive-behavioral** and **biological** mechanisms—such as serotonin dysregulation and maladaptive responsibility appraisals—recent research underscores the importance of **trauma history** as a contextual vulnerability factor.

Within counselling psychology, conceptualizing OCD through a trauma-informed lens has become increasingly relevant. This perspective emphasizes how compulsive behaviors may not merely represent attempts to neutralize intrusive thoughts, but also deeper symbolic efforts to **restore psychological safety, control, and relational trust** disrupted by trauma. For instance, chronic emotional invalidation ("small t" trauma) may cultivate rigid control patterns and perfectionism, while acute catastrophic events ("big T" trauma) may trigger heightened vigilance, contamination fears, or moral scrupulosity (Melamed et al., 2024; D'Angelo et al., 2024).

Despite emerging empirical evidence, qualitative accounts capturing how individuals themselves interpret these trauma–OCD links remain scarce. This study addresses that gap by exploring the narratives of adults diagnosed with OCD, offering insight into how experiences of relational and acute trauma shape their symptom development and maintenance.

Literature Review

1. Contemporary Conceptualizations of OCD

OCD is marked by a persistent cycle in which intrusive thoughts trigger distress, prompting repetitive behaviors to reduce that distress—thus negatively reinforcing the compulsion (Stein et al., 2024). Recent research has refined understanding of cognitive-affective mechanisms that sustain this cycle. **Morriss, Rodriguez-Sobstel, and Steinman (2024)** investigated intolerance of uncertainty (IU) and fear extinction in OCD and anxiety disorders using threat-conditioning paradigms (N = 89). Individuals with higher IU exhibited slower threat-extinction learning and increased physiological arousal, suggesting that difficulty tolerating ambiguity underlies persistent intrusive fears.

Additionally, neurobiological findings complement this behavioral evidence. Peters et al. (2016) reviewed fMRI studies on trauma exposure in OCD and found altered activation in cortico-striato-thalamo-cortical circuits—particularly the anterior cingulate and orbitofrontal cortices—regions associated with both threat monitoring and habitual control. This convergence of biological and cognitive evidence highlights how trauma-related dysregulation in fear and control systems may heighten OCD vulnerability.

2. Trauma Exposure and OCD: Emerging Empirical Evidence

Childhood and Relational Trauma

Recent meta-analytic and systematic evidence highlights strong associations between **childhood emotional abuse or neglect** and **OCD symptom severity**. **Melamed et al. (2024)** synthesized 134 peer-reviewed studies (total N = 2,55,334) and found that emotional neglect was the most consistent predictor of severe obsessions, particularly those involving aggression, sexuality, or contamination. They concluded that chronic emotional invalidation and early

relational insecurity may shape maladaptive control schemas, which later manifest as obsessive-compulsive symptoms.

Similarly, **Borrelli et al. (2024)** examined 150 Italian adults with OCD using the Childhood Trauma Questionnaire (CTQ). Emotional neglect predicted earlier onset of OCD and higher Y-BOCS scores ($\beta = .38$, $p < .01$), while physical or sexual abuse did not show the same predictive strength. These findings indicate that **small t traumas**—such as sustained relational neglect—can have enduring developmental impacts on affect regulation and perceived control.

Cumulative and Complex Trauma in Adulthood

Beyond childhood adversity, cumulative interpersonal trauma in adulthood is also associated with heightened symptom severity. In a cross-sectional study of 107 adults, **D'Angelo et al. (2024)** compared OCD participants with and without comorbid Complex Post-Traumatic Stress Disorder (cPTSD). Those with cPTSD reported significantly greater OCD symptom severity (mean Y-BOCS = 29.4 vs. 22.6, $p < .001$) and greater comorbid anxiety and depression. These results suggest that ongoing relational trauma compounds OCD symptom intensity, aligning with diathesis–stress models in which traumatic stressors exacerbate existing vulnerabilities.

Large-Scale or Acute Trauma

Evidence from **large-scale traumatic events** also supports the trauma–OCD link. In one of the most comprehensive recent studies, **Kalanthroff et al. (2025)** examined 1,048 Israeli adults six months after exposure to the **October 7, 2023 attacks**. Approximately **24 %** of trauma-exposed participants reported **new-onset OCD symptoms**, and **39 %** met clinical thresholds for probable OCD based on validated self-report measures. Notably, symptom onset was closely correlated with proximity to violence and perceived helplessness. The authors

concluded that acute trauma exposure can trigger obsessive-compulsive behaviors as adaptive attempts to restore control when reality feels chaotic. This finding provides rare, population-level evidence that **big T traumas** can precipitate or intensify OCD even in individuals without prior psychiatric history.

Together, these studies provide converging support for the notion that trauma—whether relational or catastrophic—plays a role in OCD's multifactorial etiology.

3. Mechanistic Pathways Linking Trauma and OCD

The mechanisms connecting trauma exposure and OCD symptoms appear multifaceted, spanning **neurobiological**, **cognitive**, and **affective-regulatory** domains.

- **Affective dysregulation and control:** Trauma disrupts emotional regulation, leading to chronic hyperarousal and a heightened need for control. Compulsions serve as safety behaviors to mitigate uncontrollable internal states (Pinciotti, 2023).
- **Intolerance of uncertainty:** Trauma survivors often develop a reduced tolerance for ambiguity, fostering compulsive checking or reassurance-seeking (Maheshwari & Tankha, 2024).
- **Mental contamination:** A unique cognitive-emotional construct linking trauma and OCD is "mental contamination," the subjective feeling of being internally tainted. **Corkish and Yap (2024)** found that in a sample of 245 trauma-exposed adults, higher levels of mental contamination mediated the relationship between childhood abuse and contamination-related OCD symptoms.
- **Neurocircuitry overlap:** As reviewed by **Peters et al. (2016)**, both PTSD and OCD involve dysregulation of cortico-striato-thalamo-cortical pathways, suggesting shared neural substrates underlying hypervigilance and compulsivity.

These mechanisms highlight the possibility that obsessive-compulsive behaviors are not random pathological habits but **learned, trauma-contingent control strategies** that become maladaptive over time.

4. Clinical Implications for Counselling Psychology

The integration of trauma-informed principles into OCD treatment has been increasingly emphasized in contemporary counselling and psychotherapy research. Pinciotti (2023) proposes a phased model for trauma-informed exposure and response prevention (ERP) wherein clinicians first stabilize affect and build safety before engaging in exposure tasks. Their review notes that traditional ERP may retraumatize clients if trauma histories are unaddressed, advocating for flexible pacing, grounding techniques, and emotional regulation training.

In parallel, counselling psychology emphasizes **relational safety** and **meaning reconstruction** as therapeutic vehicles. Trauma-informed OCD therapy thus extends beyond cognitive restructuring to include **compassion-based approaches**, reflective dialogue, and processing of underlying shame or fear (D'Angelo et al., 2024). The therapeutic relationship becomes the context through which clients learn to tolerate uncertainty and regain agency—core challenges for both trauma and OCD populations.

5. Gaps and Rationale for the Present Study

Despite expanding empirical data, several limitations persist in the literature:

1. **Qualitative scarcity:** Most studies are quantitative, limiting insight into the subjective meaning-making that connects trauma and OCD.
2. **Trauma-type differentiation:** Few studies explicitly contrast "small t" versus "big T" trauma trajectories in OCD development.

3. **Contextual nuance:** Counselling psychology's relational focus is underrepresented; few studies examine how clients articulate compulsions as coping mechanisms within interpersonal or emotional contexts.

This study aims to fill these gaps by using a **descriptive qualitative design** that centers on adult clients' narratives. By eliciting their personal accounts, the study explores how different forms of trauma are perceived to contribute to OCD development and how compulsive behaviors function as adaptive or protective responses within those narratives.

Part 2: Methodology, Results, Discussion, and Conclusion (Observation-Based Version)

Methodology

Research Design

This study follows a descriptive qualitative, observation-based design aimed at understanding the influence of traumatic and adverse life experiences on the development and expression of obsessive-compulsive behaviors. Instead of using standardized interviews or computer-assisted software, the analysis relied exclusively on clinical observations, session notes, and behavioral patterns documented by the researcher. This approach aligns with phenomenological principles emphasizing lived experience, context, and emotional meaning (Sundler et al., 2019).

Note: Data collection and analysis are ongoing; results presented here reflect preliminary patterns derived from observed counseling sessions.

Participants

Twenty adults (13 females, 7 males) aged 16–50 years participated in ongoing counseling for OCD. Ages at symptom onset ranged from 5 to 48 years, while formal diagnosis ages ranged

from 15 to 41 years. All participants presented with identifiable obsessions and compulsions linked to significant precipitating life events. All had a **primary diagnosis of OCD** confirmed by a psychiatrist and licensed clinical psychologists using DSM-5-TR criteria and the Yale-Brown Obsessive–Compulsive Scale (Y-BOCS). Inclusion criteria required at least six months of active symptoms and a self-reported history of one or more traumatic or highly stressful life experiences. Individuals currently undergoing inpatient psychiatric treatment or exhibiting active psychosis were excluded to ensure safety and clarity of responses.

A brief demographic snapshot shows:

- **Gender ratio:** 65% female, 35% male.
- **Average age:** 31.9 years.
- **Mean gap between onset and diagnosis:** approximately 17 years.
- **Common obsessions:** fear of contamination, fear of loss or rejection, perfectionism, guilt, responsibility, and intrusive 'what-if' thoughts.
- **Common compulsions:** checking, reassurance seeking, excessive cleaning, information-seeking, and repetitive ordering.
- **Trauma types:** childhood emotional neglect, parental conflict, abuse (physical/sexual), bereavement, exposure to violence, and relational invalidation.
- **Family history:** 9 of 20 cases reported a parent with obsessive-compulsive or affective traits, suggesting intergenerational vulnerability.

Data Collection

All observations were made during regular therapy sessions between January 2024 and September 2025. Field notes captured emotional tone, language, body posture, physiological arousal, and behavioral patterns. Observational attention focused on emotional triggers

connected to obsessions, non-verbal signs of anxiety or avoidance, contextual details surrounding trauma recall, and compulsive acts performed or described during sessions. Semi-structured interviews were employed rather than standardized instruments, thereby preserving the clinical relevance of the naturally occurring therapeutic material.

Data Analysis

The researcher conducted manual thematic categorization based on repeated reading of observation logs and reflective memos. Patterns were identified through inductive reasoning rather than coding software. The process involved: 1) Case familiarization, 2) Listing recurring cognitive themes (e.g., guilt, control, fear of abandonment), 3) Grouping behaviors that served similar emotional functions, and 4) Integrating cross-case insights to form broader conceptual clusters. Themes were validated through repeated comparison across cases and reflective journaling to ensure interpretive consistency.

Ethical Considerations

All data was collected under informed consent, with strict anonymity maintained using client initials.

Results (Derived from Observational Data)

1. **Developmental and Relational Trauma as Core Vulnerability:** Early relational adversities appeared in over half of the cases. Clients RD, AM, SA, SN, and MD reported exposure to domestic conflict, strict parenting, or physical abuse. Observable outcomes included perfectionistic rituals, fear of rejection, and chronic guilt. For example, RD's reassurance-seeking mirrored a lifelong need for validation after witnessing paternal violence, whereas SA's ritualistic symmetry behaviors emerged following childhood sexual assault and maternal pressure for achievement.

2. **Acute or Catastrophic Events Triggering Symptom Onset:** Several clients showed a clear link between single traumatic events and the emergence or worsening of OCD. RA developed reassurance-seeking compulsions after witnessing her mother's self-harm and death. RP presented travel-related obsessions following a near-fatal car accident in which she had to perform CPR on her husband. AT experienced social withdrawal and avoidance rituals after observing his mother's death during a train journey.

In each case, intrusive "what-if" thoughts and guilt centered on perceived failure to prevent harm.

3. **Perfectionism and Control as Defense against Chaos:** Clients AM, SB, AR, and MD demonstrated compulsions rooted in rule-bound perfectionism and fear of mistakes. These behaviors appeared adaptive in chaotic environments. AM, raised amid parental violence, showed defensive perfectionism and argumentative reassurance behaviors ("I must not be blamed"). SB's strict adherence to rules and "should" statements developed after consecutive bereavements and betrayal, reinforcing the link between cumulative loss and control needs.

4**. Cognitive Distortions and Self-Criticism:** A recurring pattern across 14 clients was cognitive distortion of responsibility—an exaggerated sense of personal fault for negative outcomes. GA and KN exemplified intellectualizing and over-researching behaviors as protective mechanisms. Both connected knowledge acquisition with safety, echoing early experiences of instability or parental illness. Such distortions sustained the compulsive cycle by creating unrealistic self-standards.

5. **Compulsions, presented as Emotional Regulation and Re-enactment:** Compulsions frequently served emotion-regulatory purposes, observable as bodily relief following ritual performance. MN's social isolation reflected avoidance of betrayal after repeated sexual assaults;

KN's reading rituals reinstated perceived security lost after his father's death. These behaviors, though maladaptive, provided momentary grounding and mimic trauma re-enactment—"doing something" to offset helplessness.

6. **Intergenerational and Familial Influences:** Nine participants reported parents with obsessive-compulsive or mood-related traits (e.g. SA, AM, SN, SM, SB, and AB). Observationally, these clients internalized rigid moral codes, high achievement expectations, and intolerance for emotional expression. This pattern suggests that family modeling interacts with trauma exposure to reinforce obsessive-compulsive schemas emphasizing duty and guilt.

7. **Summary of Observed Links:** A detailed chart is attached as Appendix B.

Table 1

Type of Trauma/Context	**Predominant Obsession**	**Typical Compulsion/Behavior**	**Representative Clients**
Childhood neglect, critical parenting	Fear of mistakes, need for approval	Checking, reassurance seeking	RD, MD, SN
Physical/sexual abuse	Contamination, guilt, symmetry	Excessive washing, order rituals	SA, SM, MN

Type of Trauma/Context	**Predominant Obsession**	**Typical Compulsion/Behavior**	**Representative Clients**
Bereavement, loss events	Fear of harm, survivor guilt	Avoidance, repetitive recounting	AT, RA, RP
Parental conflict or control	Fear of criticism, perfectionism	Overworking, rule compliance	AM, SB, AR
Economic hardship or instability	Fear of failure, control loss	Self-monitoring, information seeking	GA, KN

Discussion

The observation-based findings show that obsessive-compulsive behaviors often emerge as adaptive responses to trauma, rather than isolated cognitive errors. Relational traumas cultivated lifelong insecurity and fear of rejection, whereas acute losses activated guilt-based compulsions focused on preventing further harm.

A consistent observation was the symbolic function of rituals: washing represented purification, checking equated to safety verification, and perfectionism restored perceived control. Compulsions thus act as both defenses and distress signals.

Intergenerational influences were salient. Children exposed to obsessive or controlling caregivers replicated similar cognitive patterns, linking family environment to the persistence of compulsive schemas. The long diagnostic delay (averaging 17 years) also highlights systemic barriers—clients normalized obsessive traits as “discipline” or “responsibility,” delaying recognition of pathology.

Culturally, the data reflected the Indian context where familial duty and achievement are highly valued. Many participants (e.g., AR, SB, AB) framed their obsessions in moral or relational terms, reinforcing the need for culturally sensitive trauma-informed approaches within counselling psychology.

Conclusion

These observational findings portray OCD not solely as a neurocognitive disorder but as a psychological expression of unresolved trauma, guilt, and loss. Across 20 cases, compulsions consistently served as mechanisms of emotional regulation, control restoration, and symbolic repair. The study, still in progress, continues to gather data to strengthen these thematic interpretations. Preliminary evidence underscores that trauma-informed counselling interventions—focusing on emotional safety, validation, and relational repair—are vital for long-term management of OCD in trauma-exposed populations.

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Appendix A

Intake Form

Client Name: _____ Date: _____

Therapist/Assessor Name: _____ Session/Intake No.: _____

1. Chief Complaint

(Main reason the person is seeking help now)

Description: What the individual says is the main issue or concern. From a trauma-informed perspective: allow the person's voice to describe it, validate their experience, and recognise that the presenting issue may be linked to past trauma.

Report: _____

2. Current Functioning (Current Situation)

Description: How the person is functioning in daily life: work/school, relationships, self-care, sleep, mood, concentration, energy, activity level. A trauma-informed lens pays attention to how trauma responses (e.g., hypervigilance, avoidance, dissociation) may manifest in these areas.

Details: _____

3. Symptoms

Description: Specific psychological, emotional, behavioural and physiological symptoms (e.g., anxiety, depression, irritability, nightmares, flashbacks, avoidance, numbing). Recognise that such symptoms may be adaptive responses to trauma.

List/Description: _____

4. Suicide Risk to Self/Others

Description: Assessment of risk of self-harm, suicidal thoughts/intent/plan/history; risk of harming others, impulsivity, access to means, protective factors. Trauma-informed practice emphasises collaborative safety planning and supports without judgement.

Risk Details: _____

- Suicidal ideation/history:

  _____

- Self-harm behaviours: _____
- Risk of harm to others: _____
- Access to means:

  _____

- Protective factors: _____

5. Drug/Alcohol Issues

Description: Current and past substance use (alcohol, illicit drugs, prescription misuse): pattern, amount/frequency, age of onset, consequences, attempts to reduce/quit. Trauma-informed: explore substance use as a coping mechanism.

Substance Use History: _____

6. Current/Past Psychological Treatment

Description: All therapy, counselling, psychiatric services, group therapy etc: dates, provider, length, outcome, engagement. From trauma-informed perspective: note whether trauma was addressed, client's experience of safety/trust in treatment.

Treatment History: _____

7. Medical History

Description: Past and current physical health conditions, surgeries, hospitalisations, chronic illnesses, neurological issues, developmental concerns. Trauma-informed: consider mind-body connections, somatic impacts of trauma.

Medical History: _____

8. Medications

Current: _____

Past: _____

Description: Include psychiatric and non-psychiatric meds; indications, doses, prescriber, adherence, side-effects. In trauma-informed care: note how medication fits into the trauma narrative (e.g., started after a traumatic event).

9. Childhood History

Description: Early developmental history: milestones, attachment to caregivers, schooling, peer relationships, early losses/separations, abuse/neglect, family environment, stability of caregivers. Trauma-informed emphasis: exploring relational trauma, attachment patterns, early coping, self-view and worldview formation.

Details: _____

10. Family History

Description: Family structure, caregivers, siblings, major events (divorce, death, migration), socio-economic context, parenting styles, family relational patterns. From a trauma lens: how family environment (e.g., parental mental health, substance use, domestic violence) may have been risk or protective factors.

Family Structure & Context: _____

Relational/Familial dynamics: _____

11. Family Mental Health History

Description: Known psychiatric diagnoses or symptoms in family members (parents, siblings, grandparents), substance use in family, suicide attempts or completions, trauma history in family. Trauma-informed: recognition of intergenerational trauma, the ripple-effects of family members' trauma responses.

Family MH History: _____

12. Work History: Current / Past

Description: Employment history (roles, durations, training, reasons for leaving), schooling, current job status, work-related stressors or trauma (e.g., harassment, accidents). Trauma-informed: note how trauma may affect vocational identity, performance, relationships at work.

Work History: _____

13. Present/Past Abuse

Description: Any history of physical, sexual, emotional abuse; neglect; domestic violence; bullying; trauma exposures (accidents, disasters, war, witnessing violence). Include age of onset, duration, perpetrator, disclosure, impact. Trauma-informed: allow for varied readiness to disclose, honour the person's narrative, avoid re-traumatisation.

Abuse History: _____

14. Stressors

Description: Current and past life stressors (financial, relational, legal, immigration, health, caregiving, bereavement). Trauma-informed: recognise cumulative stress (including ACEs – Adverse Childhood Experiences) and how ongoing stress may maintain trauma responses.

Stressors: _____

15. Current Support

Description: Social supports: family, friends, community, religious/spiritual affiliation, peer groups; available resource networks. Trauma-informed: emphasise connection, safe relational anchors, empowerment.

Support Systems: _____

16. Strengths

Description: Individual's capacities, coping skills (even if hidden), talents, successes, survival responses, values, motivations. Trauma-informed: centre the strengths (not just deficits); resilience is present even if not obvious.

Strengths: _____

17. DSM Diagnoses

Description: Based on assessment, list any formal diagnoses per the Diagnostic and Statistical Manual of Mental Disorders criteria (e.g., PTSD, depression, substance-use disorder, anxiety disorders). Trauma-informed: integrate trauma context, avoid pathologizing without context.

Diagnoses: _____

18. Goals

Description: What the person hopes to achieve (short-term and long-term). Goals should be collaboratively developed, meaningful, realistic, trauma-sensitive (e.g., increase safety, reduce distress, build relationships, enhance self-regulation, find meaning).

Client Goals: _____

Therapist/Intervention Goals: _____

19. Treatment Plan / Recommendations

Description: Detailed plan of intervention: therapeutic modalities (e.g., trauma-focused therapies, CBT, EMDR), frequency, provider(s), referrals (psychiatry, medical, substance use, vocational, legal), safety plan, support services. Trauma-informed: emphasise safety, collaboration, transparency, empowerment, cultural responsiveness, avoidance of re-traumatisation, build relational trust and resilience.

Plan & Recommendations: _____

Referrals/Next Steps: _____

20. Follow-Up

Description: When next contact will occur, what will be reviewed, how progress will be monitored, what measures/indicators will be used, contingency plans if risk increases. Trauma-informed: schedule consistent follow-up, reassure ongoing support, monitor trauma reactions over time, revisit safety plan.

Next appointment/date: _____

What to review: _____

Monitoring/Indicators: _____

Contingency/Safety plan: _____

Signature (Assessor): _____ **Date:** _____