How I Treat OCD Killer Thoughts:
Treating Violent Obsessions

By: Fred Penzel, Ph.D.

There are dozens of categories of different obsessions and compulsions that make up the disorder known as OCD, and while these cover a wide range of differing themes, they all share many characteristics in common. These would include intrusive, unpleasant thoughts, unceasing doubt, guilt, fears of being insane and crushing anxiety. While all forms of OCD can be painful, paralyzing, repulsive, and debilitating, one of the nastier and more startling is the type known as morbid obsessions. This is particularly true of those obsessions in this category that are violent in nature, and include thoughts of killing or injuring others or oneself, or of acting sexually in ways that are against society's norms. I include thoughts of acting out sexually in this category, as they really represent a form of violence, and have little to do with sex.

Violent thoughts may involve both mental images and impulses to act. These can include those in which people see themselves hitting, stabbing, strangling, mutilating or otherwise injuring their children, family members, strangers, pets, or even themselves. They may envision themselves using sharp or pointed objects, such as knives, forks, scissors, pencils, pens, broken bottles, letter openers, ice picks, power tools, poison, their bare hands, or even their cars. The urges they experience may involve pushing or throwing themselves or others into the paths of trains or cars, out of windows, or off balconies, buildings, or other high places.

Some report thoughts of hitting pedestrians, ramming their cars into bridge abutments on the highway, or steering into the path of oncoming traffic. Others fear snapping or going berserk in public and harming people. One patient of mine would have thoughts of opening one of the exit doors aboard an airliner. In reaction, sufferers tend to fear being alone with anyone smaller and weaker they feel they could easily overpower, such as children and elderly people. They often avoid going to such places as train platforms, pedestrian-filled street corners, or being in crowded public places. Mothers may experience repeated thoughts of acting violently towards their infants or small children. Sexual thoughts in this category usually involve raping or sexually abusing children or other adults. Fears of acting out other sexually inappropriate behaviors may also occur.

Although the number of people who suffer from this type of OCD is still not exactly clear, it is probably more common than most people think. I would estimate that about a third of my patients suffer from some form of them. When most of my patients begin treatment, they believe that they may be insane, and that no one else could think as crazily as they do. I am usually able to convince them that neither of these things is true, and this is further confirmed for them when they attend a support group and hear others report the same types of thoughts. Another problem these sufferers seem to be burdened with is a nagging doubt that causes them to ask themselves," What kind of person am I that could think such thoughts? Why would I think these things if I didn't really want to do them. I must be a psychopath or a pervert." Not being able to resolve this doubt obviously results in a lot of anxiety.

In years past, OCD sufferers who went for treatment via psychoanalysis were mistakenly informed that their thoughts actually represented repressed anger and that they unconsciously wished to do

the things they were obsessing about. This only worsened the symptoms for these unfortunate people. Sad to say, treatment of this type still continues in many places. In one case I know of, a woman confessed her obsessive thoughts of hurting her child to a psychiatrist. She was rewarded by this professional reporting her to state protective services, who then promptly investigated her with an eye to removing her child from her home.

It is important for sufferers to understand that the thoughts are just thoughts, and do not cause anxiety, but rather the anxiety is caused by the views sufferers take of the thoughts. They need to overcome the idea that, "If I think it, it must be real." It should be noted that people who suffer from these thoughts have no history of violence, nor do they ever act out on their ideas or urges. Although OCD can project extreme and bizarre thoughts into people's minds, it is not the thoughts or the anxiety, as much as people's solutions to having the thoughts that represents the real heart of the problem. It is the compulsive acts that people perform to relieve their anxiety that cause the paralysis that they experience. Compulsions are seductive, in that they offer the illusion of immediate relief from anxiety, even if it only lasts a brief time. Compulsions paradoxically, start out as solutions, but eventually become the problem itself. They may grow from taking only a few minutes per day, to taking up hours at a time.

Instinct tells people with OCD to avoid or run away from the things they fear, and they erroneously believe that this is possible. Unfortunately, the opposite proves to be true, and the avoidance only worsens the problem and increases the fear. A person's whole life may become oriented around never coming into contact with the things that make them anxious. In actuality, you cannot run from what you fear. It must be faced. People with OCD do not remain in the presence of what they fear long enough to learn the truth of things, which is that nothing would happen even if they did no compulsions. Regardless of the type of obsessions, treatment for OCD is all about getting sufferers to accept that their solutions do not work, and will never work, and that they have to finally face their obsessive thoughts while resisting their urges to do compulsions. Anything short of this will not be powerful enough to get the job done.

These principles are put into action in a treatment known as Exposure and Response Prevention (E&RP). This is a systematic way of confronting the violent (or any other) thoughts in a step-by-step manner. The actual exposure itself is very straightforward. Sufferers can be exposed to violent thoughts in a number of ways. These may involve assignments carried out under a therapist's direction in an office, or on one's own, at home. What all these methods have in common is that they don't reassure. Instead they are designed to provoke anxiety by essentially saying that the thoughts are true, that the feared consequences will really happen, and that nothing can be done to prevent them. Ideally, exposure should be done whenever and wherever the thoughts occur. Those who suffer from violent obsessions have various types of scripts they write for themselves, and it is important to understand these scripts in order to be able to use them in designing homework assignments. A typical script for violent thinkers runs something like, “I must be having these thoughts because I'm really psycho and want to do these things. Maybe I'll lose control and really do them. If I do act on my thoughts, they'll lock me up forever. That will be horrible for my family and me; they will suffer because of what I did, and I will suffer knowing what I did to them and to my victim. I won't be able to live with the guilt. I'll either die in prison, or kill myself." Scripts such as these are worked into a series of graduated assignments.

I usually prescribe assignments based on a hierarchy we create, which rates all of the person's feared thoughts and situations in terms of the strength of the anxiety they cause. We begin with only those items lowest on the fear scale, and gradually work our way up, going at the patient's own pace. No one is forced to do anything they are not ready to tackle. If a particular assignment cannot be done in a whole step, it may be broken down into smaller steps. Each hierarchy and group of assignments is tailored to each person's symptoms. Treatment is home-based (also known as self-directed treatment) and outpatient. Homework is given weekly in written form, and done outside the office, with instructions to call if necessary. Most people have between 4 and 12 different assignments per week. In the majority of cases, treatment is on a once per week basis, requiring one 45-minute session to debrief the past week's homework, to give the next series of assignments, and discuss other ongoing issues in the person's life that may need attention.

The assignments usually begin with things that are more general, and only provoke a moderate amount of anxiety. Over time, they gradually become more specific, and get people to expose themselves to more and more challenging things. It is here that therapists are called upon to show their flexibility and creativity. We go wherever we have to go, and do whatever it takes to create therapeutic situations that will help the person to confront their thoughts.

Behavioral therapy cannot be done in cookbook fashion. It is usually suggested to the patient at first, that there are people out there who are capable of violent acts, and who may lose control and act without warning. The exposure then moves on to suggest that the patient, themselves, just might be capable of the sorts of things they may be thinking about. From there, we move on to confronting the idea that there is a real possibility that they will snap, and commit a violent act. Following this, the next step has the patient expose themselves to the thought that they will definitely do whatever it is they are obsessing about, and that it may happen at any time without warning. At this stage, if the patient is particularly doubtful, it may also be appropriate to suggest that they have even done the feared thing recently, or in the past.

Moving through these various stages can span a period of months, and the whole process can take approximately 6 to 9 months overall. Those with the more serious and debilitating problems may need to come more than once a week or for a longer period. A few of the most serious cases may even need to work within a hospital setting, if they are unable to follow treatment on their own, although this is much less common and rarely necessary.

One good exposure technique is via audio taped presentations of these feared ideas that run several minutes in length, and are used several times a day. Other methods could include reading books or news articles that provoke the violent thoughts, writing brief essays on why the thoughts represent true desires, visiting websites related to violent or sexual offenders, hanging up signs with phrases that evoke anxiety, writing feared words or phrases repeatedly, or voluntarily seeking out real-life situations likely to bring the thoughts on. With regard to this last technique, it can be quite helpful to set up little plays to help the person confront a feared situation in a somewhat realistic way. One example of this would be the case of a young man who had thoughts that he would stab his father. We set up a nightly exercise where he would sit next to his father on a sofa watching TV together, as the patient held a large kitchen knife in his hand. Periodically, his father would turn to him and say seriously, "Please don't kill me, son."

An important factor to also build into these techniques is repeatedly exposing the person to the idea that the escape or avoidance maneuvers they typically use, cannot and will not work. Probably the most important assignment I ever give patients is for them to agree with each violent thought as it occurs, rather than trying to argue with or analyze them. They probably get more opportunities to do this assignment than any other.

When first considering E&RP, people tend to ask, "Won't this treatment make me feel worse?" The answer is that it may, at least to start. By staying with what you fear, you may feel more anxious at first, but you will gradually build up a tolerance to the feared thing. I like to tell my patients, "You can't be bored and scared at the same time." The ultimate goal is total immersion, so that exposure takes place in a variety of ways throughout the day. The more total it is, the quicker you will get used to what you have feared, and the sooner the fear will subside. This may not be as easy as it sounds, especially in the face of really repulsive, violent thoughts. Obviously, the real art of doing therapy involves getting people to trust what the therapist is telling them, and that the method will work for them. By the time we get to the end of a person's hierarchy, there is little left in it that can bring on anxiety. They can think the worst of their thoughts, but not feel that they have to react to them.

The following list is included to show what some typical behavioral assignments might look like. No list can be complete for all people, so this is just a sampling. Understand that some of these are advanced assignments presented in no particular order, and you would work up to doing them over time. Note that no one does assignments such as these until they are ready for them.

Thoughts of running into people with your car:
- Reading news articles about hit-and-run accidents
- Driving down crowded streets or around shopping malls
- Driving down dark roads at night

Thoughts of stabbing people:
- Gesturing at others with utensils, while eating
- Sitting close to others at home holding a large knife

Thoughts of hitting people:
- Walking down a crowded street and brushing against people
- Patting people firmly on the back
- Gesturing toward people while standing close to them
- Watching stabbing scenes in movies

Thoughts of molesting children:
- Reading about child molesters who got caught
- Standing close to children in public
- Holding one's own children or cuddling them (young children)

Thoughts of harming your infant:
- Looking at articles about child abuse
- Holding your infant standing near an open window
- Reading about parents who killed or injured their children

Thoughts of stabbing yourself:

Writing a composition on how you will lose control and harm yourself
Sitting with a knife or pointed object in front of you on a table
Holding a knife or sharp object pointed at yourself

Fear of going berserk in public:
Walking around in public with a knife in your pocket
Walking with a knife in your pocket listening to a tape telling you that you will lose control
Standing behind people on a crowded train platform
Reading news articles about people who lost control in public

I like to make patients aware that many people they may encounter will not be particularly sophisticated or familiar with behavioral therapy or the purpose of its homework assignments that don't sound like your typical talk therapy. In discussing it with others, including family members or even physicians, they may get negative reactions. One psychiatrist gravely informed one of my patients that the therapy sounded very extreme and risky to him, and that he had his doubts about it. This obviously did little for my patient's motivation, and it took a bit of doing to get him to get back to work, while accepting that his physician just wasn't well acquainted with E&RP, and was commenting on something he knew little about.

Finally, I would like to share some rules that my patients find helpful in dealing with violent thoughts and other forms of OCD:

1. Expect the unexpected -- you can have an obsessive thought any time or any place.

2. Never seek reassurance. Instead, tell yourself the worst will happen, or has happened

3. Always agree with all obsessive thoughts -- never analyze or argue with them.

4. If you slip and do a compulsion, you can always mess it up and cancel it out.

5. Remember that dealing with your symptoms is your responsibility alone.
   Don't involve others

6. When you have a choice, always go toward the anxiety, never away from it.

There is a common myth that violent obsessions (and even obsessions in general) are harder to treat than other types of symptoms. This is absolutely false. Regardless of your symptoms, you can be successfully treated if the correct techniques are used, if you accept that you cannot go on as you have, and if you are prepared to do whatever it takes to recover and regain control of your life.

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