

# Treating Morbid Obsessions

by Fred Penzel, Ph.D.

One of the less well understood areas of OCD is the area of morbid obsessions. This category includes thoughts of killing or injuring others, of having death or injury inflicted on one's self or loved ones, of acting sexually in ways that are either unnatural to the person or against society's norms, or finally, thoughts of acting inappropriately in public (e.g. taking off one's clothes, shouting obscenities, making rude gestures, etc.).

I think that we must be careful here to define what an obsession is. Unfortunately the term has been mistakenly used to describe both unpleasant repetitive thoughts and the mental rituals people use to neutralize them. It is my belief that only the former are obsessions; the latter are actually mental compulsions. Simply put, obsessions cause anxiety, while compulsions reduce anxiety.

I also believe that the reason that morbid obsessions (as well as the other types) have long been mistakenly labeled 'hard to treat' is due to three reasons. First, that practitioners often fail to distinguish between obsessions and mental compulsions. Second, that many practitioners fall into the trap of being distracted by the content of the thoughts themselves, failing to recognize them as obsessions. Such thoughts are often treated as genuine desires and impulses and the practitioner tries to 'help' the person 'control' them, or else gets lost in endless discussions of what the thoughts 'really mean'. The harm this inflicts is immense, not only for the anxiety it raises, but also because it may raise new morbid topics to obsess about. Third, that practitioners are not utilizing effective, existing techniques to their fullest.

With that established, let us get back to morbid thoughts. While there have not been many good studies about the incidence of morbid thoughts, my own experiences as a clinician tell me that they are fairly common in OCD. I would estimate that about half of my patients suffer from some form of them. When most of my patients begin treatment, they seem to believe that no one else could be as 'crazy' as they are, a notion which is usually ended both when I am able to tell them much of what they haven't yet told me they are experiencing, and when they attend a support group and hear others say the same things. Another problem sufferers seem to be burdened with is a doubt that asks "What kind of person am I that could think such a thought? I must be a psychopath or a pervert." Not being able to resolve this doubt causes a lot of anxiety.

Morbid thoughts can be extremely unpleasant, ugly and debilitating, but they are not unbeatable. One word of caution: we lack valid treatment studies here, so I must draw on my own ten years of clinical experience with OCD. I believe that morbid obsessions must be treated behaviorally by gradual and direct confrontation via exposure and response prevention (E&RP). The thoughts themselves are easy to identify; however, many clinicians fail to spot the compulsive avoidance maneuvers that people use to escape the accompanying anxiety. Where these compulsions are happening out in the open, e.g. questioning, praying or touching rituals, counting, or simple physical avoidance, they are, again, possible to spot and suppress. What are less easy to identify are the mental compulsions, designed to neutralize the thought or ensure that the feared event will not happen. If these are not also dealt with, the treatment will not be a successful one. I have rarely seen someone have a morbid thought without having some type of accompanying compulsion.

Mental compulsions may include thinking opposite or neutralizing thoughts, images, words, numbers or prayers, or arranging thoughts in a special order, to name a few. Despite the fact that you may be confronting the thoughts, the mental compulsions will still be relieving the anxiety, thus strengthening both the need to keep ritualizing, as well as the belief in the thoughts.

The obvious course of action here, is to not only have, the person expose themselves to the thoughts on a systematic basis, but also to help the person eliminate or counteract the accompanying compulsions. Where sufferers run into trouble with morbid thoughts, is that they do not stay with them long enough to see that the anxiety and preoccupation would subside without the ritual or avoidance. Some might point out here that feared consequences can be in the far future. Others might ask, "If the origin of my morbid thoughts is biological and possibly even genetic, how can changing my behaviors in dealing with them help?" The answer is that OCD is a disorder that has both biological and behavioral aspects. The biochemical problems with serotonin are the basis for the thoughts. However, what frequently worsens and maintains the thoughts are the habitual ways with which a person responds to them through avoidance or compulsion. Behavioral therapy seeks to retrain persons to establish newer, different habits which will not contribute to their obsessions.

The principle behind E&RP is that via repeated exposure to feared thoughts or situations and when escape or avoidance are resisted, something called 'habituation' happens. That is, the sufferer's tolerance for the thoughts or situations gradually increases with each exposure, and these thoughts cause less and less of a fearful reaction. Eventually, with enough exposure, the thoughts can provoke little or no anxiety and do not disrupt the individual's life. When handled the wrong way (as most people do at first) morbid thoughts cause a sort of vicious circle; the more you work to compulsively neutralize them, the more the avoidance, fear and belief in them are strengthened, and the worse they get. Additionally, the stress generated in trying to 'perfectly' avoid or cancel the thoughts also leads to more thoughts.

The actual exposure itself is very straightforward. Sufferers can be exposed to morbid thoughts in a number of ways. What all these methods have in common is that they don't try to reassure. Instead they are designed to evoke anxiety by essentially saying that the thoughts are true and that the feared consequences will happen. Ideally, exposure should be done whenever and wherever the thoughts occur. One good technique is via taped presentations several minutes in length, used several times a day. Other methods could include reading books or articles that provoke the thoughts, writing essays on why the thoughts are really true, or voluntarily seeking out real-life situations likely to bring the thoughts on. An important factor to also build into these techniques is repeatedly exposing the person to the idea that their escape or avoidance maneuvers cannot and will not work.

I usually prescribe these assignments based on a hierarchy which rates all the 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. Each hierarchy and group of assignments is tailored to the particular person's symptoms. Treatment is home-based and outpatient. Homework is given in written form weekly to be done outside the office, with instructions to call if necessary. In the majority of cases, treatment is on a once a week basis, requiring one 45 minute session to debrief the past week's homework, discuss other ongoing issues in the person's life, and to give the next series of assignments. Most people have between 4

and 12 different assignments per week. The whole process takes about 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 hospitalization, although this is much less common or necessary.

In addition, I have found antidepressant medication to be very helpful as a co-treatment, especially where obsessions are concerned. However, if someone is reluctant to take them, the issue should not be forced. Medication can frequently reduce the level of thoughts or their strength, making it easier for the person to accomplish homework assignments and sometimes even just shrug thoughts off. When the person has been in a state of recovery for 6 to 12 months, they can then try reducing their medication, even discontinuing it, if symptoms do not appear to be a further problem.

To conclude, morbid obsessions are not 'the end of the line;' they can be treated, and there is hope for recovery from even the nastiest thoughts. Just make sure that what you are receiving is truly behavioral therapy of the correct type, and that your practitioner is trained and experienced enough to do it correctly.

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