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Obsessive Thoughts: The Problem of Therapy

By R. S. STERN

SUMMARY Eleven patients with obsessive thoughts were treated in two pilot studies. In the first of these patients were given thought-stopping, and this was contrasted with relaxation therapy. In the second study patients were treated by a technique described here as 'satiation', and this was followed by thought-stopping and finally a course of amitriptyline. The overall results were poor, but one type of obsessive thought responded well to satiation.

Introduction

There is no consensus of agreement as to the best treatment for obsessive thoughts. Favourable case reports using thought-stopping procedures have been described (Stern, 1970; Yamagami, 1971; Cautela, 1969; Wolpe and Lazarus, 1966; Campbell, 1973). In a conrolled study Stern *et al* (1973) found that tape-recorded thought-stopping had a weak therapeutic effect, and where there was improvement this occurred as much after stopping neutral as obsessive thoughts. Though Hackmann and McLean (1975) found that thought-stopping reduced thoughts and rituals as effectively as flooding, the effect on obsessive thoughts was not given separately from that on rituals. Emmelkamp and Kwee (1977) treated five cases by thought-stopping and prolonged exposure in imagination and found no differences between these two procedures.

Therapeutic advances in recent years have shown that compulsive *rituals* yield successfully to treatment using behavioural approaches such as exposure-*in-vivo*, modelling and response prevention (Meyer *et al*, 1974; Boulougouris, 1977; Marks *et al*, 1975). The present study was an attempt to discover a reliable treatment for that variety of obsessive-compulsive neurosis which is least successfully dealt with by the above approaches: obsessive thoughts.

Method

During the course of selecting patients with severe compulsive rituals for another study, all those patients who did *not* have significant rituals but were disturbed by serious ruminations were chosen for the following studies.

Pilot Study 1

Thought-stopping v. relaxation

Four patients with classic obsessive thoughts were randomly allocated to start either with thought-stopping or with relaxation given as the control treatment in a small cross-over design. Patients had four weekly sessions of each treatment, each session lasting 60 minutes. Thought-stopping began by asking the patient to bring on the rumination as strongly as possible. After about 30 seconds the therapist made a sharp noise by tapping on the desk and the patient was told to shout 'stop' simultaneously with the noise. If tapping the desk did not disrupt the thought, an elastic band was snapped on the wrist to achieve the same effect. If this failed, the patient was trained to switch to a pleasant image such as 'lying on a sunny beach' to disrupt the obsessional thought. Eventually the patient was taught to use decreasingly aversive stimuli, i.e. instead of shouting 'stop' he said the word in a normal voice; eventually he merely whispered it and

finally, he was taught to achieve control by a subvocal self-command.

Measures of change included patient ratings of distress from obsessive thoughts on a 0–8 scale, patient ratings of obsessive activity checklist (Marks *et al*, 1977), and the Wakefield Depression Inventory (Snaith, 1971).

Pilot Study 2

Seven patients with severe obsessional thoughts were first given four weekly sessions of *satiation*, which could also be called exposure in fantasy or paradoxical intention. The rationale for this is that patients repeatedly try to escape the obsessive thoughts and need to habituate to long periods of exposure to them. The aim was to encourage patients to ruminate so intensively, for an hour at a time that the rumination would eventually lose its abhorrent or unpleasant quality by the end of the session. In each session the patient was asked to speak the rumination out loud in the presence of the therapist, and the latter would encourage him in this and provide verbal prompts. Instructions were also given for patients to carry out homework sessions by writing down the thought time and time again. A third component of satiation was cue exposure: the patient was told to bring himself into contact with people or objects likely to bring on the rumination. This phase was followed by four weeks without therapy, to act as a buffer phase.

Thereafter the second approach was four weekly sessions of thought-stopping, carried out as described for 60 minutes with homework instructions to continue this procedure at home instead of satiation. This was followed by a further month without treatment.

In the third phase, amitriptyline was given, gradually increasing the dose to 200 mg daily and maintaining patients on this dose according to clinical response for up to six months.

The 11 patients from the two pilot studies combined were subsequently categorized into four types:

Type I: Doubting-philosophical ruminations (5 cases in Study 1, 1 in Study 2)

An example of this type was a patient who complained that he could not concentrate because of a preoccupation with religious ideas. He constantly thought about whether he had committed a sin: 'While I'm on this earth I'll be evil . . . but wait, no, God is going to punish me for this.' These philosophical speculations went on in his mind constantly as if he was debating with himself. He realized his arguments were illogical, e.g. 'I should not be allowed to live, I should be made ugly and pathetic because I'm evil . . . but no, it isn't my fault, I'm only thinking this way because I'm sick.' Satiation with 'evil thoughts' and thought-stopping had no effect.

Type II: Horror-disgust ruminations (2 cases in Study 2)

Example: a patient had a distressing thought 'Did I touch that man (or woman) on the knee?' She had an underlying thought that because of her rumination all her friends would consider her a 'sex maniac' to her great embarrassment.

During satiation she imagined herself sitting next to a man in the train and having the desire to squeeze his knee, and imagined actually carrying this out. She was asked to imagine the possible consequences: 'The man is shocked and horrified and everyone in the train looks at me. At work everyone talks about me, saying I am a sex maniac.'

Type III: Guilty-depressive ruminations (1 case in Study 2)

The patient suffered from guilty ruminations that he had somehow caused accidents to occur after reading about these in the newspaper. After reading 'ten victims found frozen to death in cars after blizzard' he would ruminate that he was in some way to blame for this. He had no feelings of associated horror, however, and felt no anxiety when he read newspaper accounts of disasters throughout the world.

Type IV: Pleasurable-gratifying ruminations (2 cases in Study 2)

Example: a patient ruminated about erotic thoughts and was worried by this as it prevented him from concentrating on other

things. The problem began a year before, after he had seen some pornographic material and began to ruminate about the fantasy of people having sexual intercourse with animals. During satiation he was made to think these thoughts aloud, which he did with no difficulty or associated horror. Neither satiation nor thought-stopping had any effect on his symptoms.

Results

None of the four patients treated with relaxation improved and only one showed slight improvement with thought-stopping. One patient became depressed and required a tricyclic drug, upon which the obsessive thoughts improved somewhat.

In the second pilot study good therapeutic results were only obtained for two patients, and this was with one technique; satiation.

Table I summarizes the results for both pilot studies, and Fig 1 shows the results for four patients with different types of obsessive thought. On the figure the patient's rating of distress from obsessive thinking is plotted as this was found to be the most sensitive and clinically relevant measure. Depression is also charted, and improvement in this closely parallels that for obsessive thoughts. It will be recalled that patients were selected only if rituals were absent, and no patients developed these during treatment. The two patients who improved significantly with satiation both had thoughts which produced horror or disgust.

TABLE I

Summary of experimental treatments

Patient's obsessive thought	Main emotion	Satiation (patients 5–11 only)	Thought stopping	Anti-depressant drug
1. Are people communicating to me in a special way?	Doubt		0	1
2. Have I killed somebody?	Doubt		0	0
3. Have I thrown God out of my life?	Doubt		0	0
4. Did I carry out my last action to my correct satisfaction?	Doubt		0	0
5. Will I be punished by God?	Doubt	0	0	1
6. Did I touch someone on the knee?	Horror	3	0	0
7. Did I stab my girlfriend?	Horror	2	0	1
8. Am I guilty of causing death to unknown people?	Guilt	0	0	1
9. I'm poisoning my parents	Pleasure	0	1	0
10. Young men's buttocks	Pleasure	0	1	0
11. People having intercourse	Pleasure	0	0	0

0 = no effect from treatment modality
1 = slight improvement
2 = treatment effective
3 = treatment highly effective

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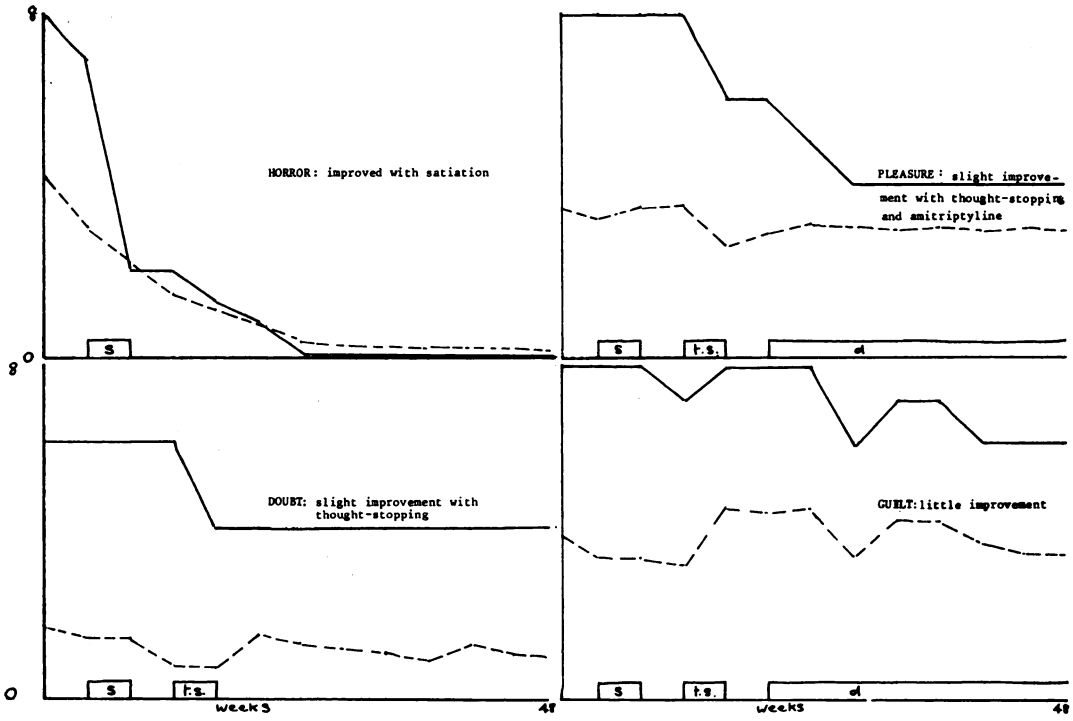

FIG 1.—Examples of four patients with different types of obsessive thoughts (horror, doubt, pleasure and guilt).

s = satiation
d = amitriptyline
t.s. = thought stopping
——— patient's rating of distress from obsessive thought (0–8)
- - - - patient's rating of depression (Wakefield scale).

The effect of thought-stopping was disappointing: only two patients in the second pilot study and one in the first improved to some extent. Amitriptyline was almost equally ineffective, four patients in all showing slight improvement.

Discussion

Taking the two pilot studies together (11 cases), thought-stopping was an ineffective procedure. This contrasts with the reports in the literature; it should be noted, however, that most reports have been of single cases (e.g. Stern, 1970 and Yamagami, 1971) or not more than three cases (e.g. Leger, 1975). The largest series comparable to the present study was that of Stern, Lipsedge and Marks (1973): the study, consisting of 11 cases, was controlled, but it could be criticized because thought-stopping was given by tape recorder and this might explain the poor results.

Thought-stopping is a procedure which consists of many variables and little research has been done into the relevance of the various factors. The aim in the present study was to meet the criticism of the Stern, Lipsedge and Marks (1973) study, giving the therapy live and by using every possible means to disrupt the thought as effectively as possible. Every technique possible was added to the procedure used here with the object of maximizing its effectiveness.

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Satiation can be contrasted with thought-stopping, and its use for obsessional ruminations seems not to have been reported except by Emmelkamp and Kwee (1977). They describe a technique called 'prolonged exposure in imagination' which they compared to thought-stopping in five cases with obsessive thoughts. A decrease in frequency of obsessive thoughts took place after both procedures, but there was no clear difference between the procedures. This is in contrast to the present study, where the two cases with horrific thoughts were both helped by satiation but not by thought-stopping.

These results suggest that some degree of classification of obsessional ruminations might lead to more rational therapeutic approaches. Obsessive thoughts of guilt usually occur in the setting of a depressive illness and so enable this type of thought to be distinguished and treated as a manifestation of depression.

This leaves three types which have been called: Horror-Disgust, Doubting-Philosophical, and Pleasurable-Gratifying. Horror-Disgust ruminations correspond closely to those described by Strauss (1948), who considered disgust to be central to the obsessive-compulsive neurosis. In their report of a cross-over study comparing *in vivo* flooding with thought-stopping, in which no differences were found between the two treatments, Hackmann and McLean (1975) state: 'It appears from an examination of the results that flooding may be more effective than thought-stopping for patients with fears of contamination.' It seems that patients with 'fears of contamination' in that study are closest to those with horror-disgust ruminations in the present study. As satiation is a version of *in vivo* flooding carried out in imagination, the present study tends to confirm that of Hackmann and McLean. In both procedures, exposure takes place for long enough to allow extinction to occur. Perhaps such patients fail to extinguish their ideas because they think them for brief periods only, because of the horrific content.

Doubting or philosophical ruminations resemble those described as 'folie de doute' by Janet (1903). Rachman (1971) argues that such ruminations are analogous to checking rituals which involve internal mental checking rather than external motor behavioural rituals. It seems unlikely that treatment analogous to *in vivo* exposure would be of much benefit, and this perhaps explains the poor results of satiation with this type of thought.

The most difficult to understand are the ruminations with pleasurable affect. It could be that such patients seek help because of the guilt they feel about possessing such ruminations and need alleviation of this guilt rather than removal of the rumination. This would explain why satiation and thought-stopping both had minimal effect for this type of rumination.

Further research is clearly needed to substantiate the suggestion from this study that horrific thoughts are worth separating from other types of obsessive thoughts, as these may respond best to satiation.

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