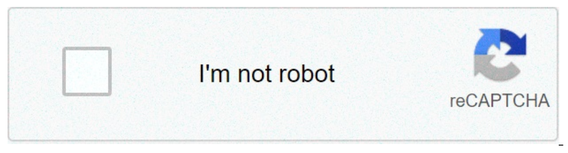

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Ocd thoughts of killing

A mom writes to ask how to help her 10-year-old daughter, who is worrying a lot about “bad thoughts.”Sometimes these thoughts are bad because they are mean: A family friend is “fat” or “wrinkly.” Sometimes they are sexual: She imagines a classmate naked. Or violent: She thinks she wants to kill her mother. They have one thing in common: she feels a need to confess all these thoughts to her mom, who wonders what’s going on.It’s a scenario we hear a lot: A child is suddenly desperate to confess disturbing thoughts. A 9-year-old noticed his teacher’s cleavage, and feels guilty about it. As his dad writes: “The more he tries to control the thoughts, the more they come.” He worries out loud that there might be something wrong with him, and asks for reassurance that he’s okay. Over and over.Kids can get very upset about these thoughts, though of course not all of them feel compelled to share them with their parents. But when they do, the constant confession and requests for reassurance can be stressful for parents, too.Why do kids worry about “bad thoughts” and feel the need to confess them? And what can you do as a parent to help them?What does this thought say about me?Jerry Bubrick, a clinical psychologist at the Child Mind Institute, reminds us that we all have random thoughts that we think, as these kids do, are bad. We may think, Wow, that was unkind, or weird, or inappropriate! And then we dismiss them. We don’t express them, or act on them, and we quickly forget about them.In contrast, Dr. Bubrick says, kids can get upset when these ordinarily fleeting thoughts get “stuck” and they are unable to dismiss them and move on. Instead of recognizing bad thoughts as meaningless, the kids hold themselves responsible for them.“These kids are placing value on themselves based on the thoughts they’re having,” Dr. Bubrick explains. So they think, There must be something wrong with me in having that thought. Or, I must be a horrible person if I’m having that thought.”Dr. Bubrick calls it “over-responsibility of thought”—kids literally holding themselves responsible for their thoughts, instead of letting them go. “And that’s why kids feel compelled to confess. They’re asking parents for reassurance, for a parent to say, ‘Yeah, that’s okay. Don’t worry about it,’ ” he adds. “That calms that fear: Okay, I’m not a bad person.”Why do some thoughts get stuck?Thoughts are often driven by emotional states, Dr. Bubrick notes. For example, “when I’m happy I’m more likely to have happy thoughts, and when I’m scared I’m more likely to have scary thoughts. When I’m hungry I’m more likely to have thoughts about food.” When we get frustrated or angry, we can all relate to imagining bad things happening to the person who’s standing in our way. But most of us don’t become alarmed or self-critical based on our thoughts alone—what matters are the actions we take. Becoming fixated on “stuck” thoughts can be a symptom of anxiety, whether it’s just an anxious personality or a full-blown anxiety disorder.What kids consider “bad” depends on the culture and what they’ve been taught. In religious families, for instance, kids worry about “bad thoughts” they think might offend God. Sexual thoughts are not infrequently disturbing to boys, especially before puberty makes talk of sexuality common among their teenage peers. Worries about wanting to murder people are surprisingly common in young children. Rachel Busman, a clinical psychologist at the Child Mind Institute, treated one 10-year-old girl who felt she needed to sit on her hands because she had thoughts about strangling someone.Kids who feel compelled to confess and ask for reassurance are usually less than 12, Dr. Bubrick notes. “Older kids tend not to tell parents what they’re thinking, I would imagine, because the thoughts are darker or scarier. They’re more sexualized, or they’re more violent.”How can we help kids handle ‘bad thoughts’?The goal is simple: to help kids recognize that their thoughts are just thoughts.“Just because you have a thought—whether it’s a good or a bad thought—doesn’t make it true,” Dr. Bubrick explains. “A bad thought doesn’t make you a bad person—It just means you’re having that thought. “That’s the message clinicians use when they treat kids with anxiety disorders using cognitive behavioral therapy. Kids are taught to identify their obsessive thoughts as separate from themselves—as a “bully in the brain,” as Dr. Bubrick puts it. “When thoughts get stuck in our mind, they kind of bully us into thinking they’re more important than they are,” adds Dr. Busman.“Seeking reassurance is a way to relieve the distress or anxiety,” she says. “And it works, for the moment.” But the only way to stop the cycle of getting stuck on intrusive thoughts and asking for reassurance is to learn to tolerate the distress without confessing, and see that the anxiety will fade.If bad thoughts really become a problem for a child—if they continue, if they cause great anguish or interfere with the child’s functioning, it may be a sign of an underlying anxiety disorder that deserves professional help. by Fred Penzel, PhD This article was initially published in the Summer 2004 edition of the OCD Newsletter. 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, stranger’s 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 hand’s, 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 (ERP). 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 ERP, 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 ERP 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: Expect the unexpected — you can have an obsessive thought any time or any place. Never seek reassurance. Instead tell yourself the worst will happen or has happened. Always agree with all obsessive thoughts — never analyze or argue with them. If you slip and do a compulsion you can always mess it up and cancel it out. Remember that dealing with your symptoms is your responsibility alone. Don’t involve others. 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. Fred Penzel, PhD is a licensed psychologist who has specialized in the treatment of OCD and related disorders since 1982. He is the executive director of Western Suffolk Psychological Services in Huntington, Long Island, New York, a private treatment group specializing in OCD and O-C related problems. — Back to Expert Opinions >> Subtypes of OCD