Clinical research on the purely obsessional patient is considerably less developed than that for compulsive ritualizers or obsessive compulsives with mixed features. A single case investigation of exposure therapy in the treatment of obsessive ruminations is presented. Treatment involved exposing the patient to a variety of stimuli related to obsessional thoughts including reading, writing, and listening to such content. The patient's immediate response to treatment was favorable, with improvements being maintained at two-year follow-up.

Clinical Social Work and Obsessive Compulsive Disorder

A Single-Subject Investigation

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Obsessive compulsive disorder (OCD) is among the most intriguing clinical conditions one may encounter in practice with individuals suffering from pathological anxiety. The OCD syndrome is often extremely handicapping, and in exceptional cases the performance of compulsive rituals and/or preoccupation with obsessional ruminations may come to dominate the individual's life. The clinical features of OCD seem to fall into two broad categories. The first category involves compulsive rituals, which are " . . . repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, or according to certain rules or in a stereotyped fashion" (American Psychiatric Association [APA], 1987, p. 247). The second category includes obsessions, defined as "recurrent or persistent ideas, thoughts, impulses, or images that are experienced, at least initially,

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BEHAVIOR MODIFICATION, Vol. 13 No. 4, October 1989 459-470
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as intrusive or senseless. . . ." (APA, 1987, p. 247). Rituals usually take the form of cleansing activities such as excessive handwashing or cleaning one's environment; repetitive counting or touching; "checking" activities, such as repeatedly examining door locks or lights to be assured that all is in order; or, more rarely, compulsive slowness—a profound and pervasive retardation and meticulousness in one's actions that makes the performance of ordinary tasks such as shaving, toothbrushing, or paperwork extremely time consuming.

Most individuals who meet the criteria for OCD present with a mixture of features, usually both rituals and obsessions. Many rituals seem to be stimulated by the occurrence of obsessional ideations that usually take the form of images, thoughts, or impulses related to violence, sex, or the potential occurrence of untoward events. The ritualizer who is not troubled by obsessions, or the purely obsessive individual, is relatively rare among patients with OCD.

Little definitive information is available regarding the etiology of OCD. Although the disorder seems to run in families and the condition may be associated with nonspecific or "soft" neurological signs, biological factors have not yet been shown to account for most cases of the disorder (cf. Thyer, 1987). Psychodynamic formulations are prevalent, beginning with an early case of Freud's, "The Rat Man" (a person with OCD troubled by intrusive thoughts about voracious rodents burrowing into his anus). This case stimulated psychoanalytic theorizing about the etiological role of anal fixations in OCD. To date, however, no such psychodynamic mechanism has been shown to account clearly for either rituals or obsessions in such patients.

Behavior therapists have generated some productive speculations and empirical investigations concerning the operant and respondent conditioning processes that may maintain OCD phenomena. For example, it is known that the performance of compulsive rituals is negatively reinforcing by reducing aversive effects and physiological arousal. Similarly, exposing patients with OCD to stimuli that provoke rituals heightens subjective distress (cf. Marks, 1987). Nevertheless, a comprehensive formulation of the original onset of OCD based on social learning theory remains elusive.

Males and females seem equally likely to present for treatment of OCD (cf. APA, 1987), and the average age of onset of the disorder

among clinic patients is in the mid-twenties (Thyer, Parrish, Curtis, Nesse, & Cameron, 1985), though many individuals develop the disorder earlier.

The relative paucity of knowledge concerning the etiological mechanisms of OCD has not precluded the development of a number of highly effective behavioral therapies that can benefit OCD sufferers. Formost among these approaches are the techniques of exposure therapy and response prevention (ETRP). ETRP is a procedure wherein the compulsive ritualizer is persuaded to voluntarily come into contact with environmental stimuli that are normally avoided because they elicit the performance of rituals. Examples may include touching objects that the patient fears are somehow "contaminated," (an event that usually provokes washing rituals) or performing some action "incorrectly," which usually provokes the person to repeat the act continually in the correct manner. With careful guidance and support of the therapist, the patient is encouraged to engage in those activities that stimulate compulsive rituals and to refrain scrupulously from ritualizing. This usually provokes a good deal of subjective anxiety and autonomic arousal, and patients may be overtly agitated and upset. With the passage of time, however, it has been both experimentally and clinically shown that the obsessive compulsive will usually calm down in the absence of performing the rituals, which usually serve to reduce anxiety. By continually repeating such experiences, increasing the intensity of the exposure (for example, by moving up a real-life hierarchy of stimuli the individual is afraid to touch), and lessening the therapist's involvement, the patient initially learns to tolerate such exposure and eventually is only minimally upset by it, thus reducing the incidence of compulsive rituals.

Although relatively simple to describe in theory, the actual conduct of ETRP requires a great deal of clinical skill and acumen. This combination of approaches, ET and RP, has been shown to be superior to either technique used in isolation. Moreover, patient response to ETRP is not appreciably improved through the use of therapeutic adjuncts such as relaxation training, biofeedback, cognitive therapy, or antianxiety medications (cf. Marks, 1987).

Dozens of well-controlled clinical studies have been conducted on the treatment of compulsive ritualizers using ETRP and its variants,

and approximately 75% of OCs offered this therapy are willing to undertake it – a level of acceptability similar to that found for conventional verbal psychotherapy. Of those who undertake treatment, the vast majority experience substantial therapeutic benefits that multiyear follow-up studies have shown to be quite durable. Complete "cures" remain the exception, however, with patients requiring continuing vigilance against the reemergence of ritualistic behaviors while usually retaining a considerably smaller degree of compulsive rituals (cf. Marks, 1987; Thyer, 1987; Steketee, 1987).

Clinical research on the treatment of the purely obsessional patient is much less well developed than that for the overt ritualizer. This is accountable, in part, to the relative scarcity of such patients and the difficulties inherent in assessing therapeutic change among those private events that have come to be called "obsessions." It is a widely held misconception that behavior therapists are interested only in obtaining changes in patients' overt behaviors, a view that is difficult to account for given the seminal work of behaviorists in the effective treatment of primarily affective disorders such as anxiety and depression. Behavior therapists have pioneered the development of reliable and valid assessment methods to monitor clinical phenomena such as obsessions, delusions, hallucinations, sexual arousal, depressed and anxious affects, pain, and cravings for alcohol and other drugs – all very "real" events that may lack naturally occurring observable indices (see, for example, Ciminero, Calhoun, & Adams, 1984).

Most accounts of the clinical management of the purely obsessive patient who lacks a ritualistic component in his or her presentation remain at the level of anecdotes and single-subject investigations. In his recent review, Marks (1987) found only two studies involving six obsessional patients and several containing five such patients. As in the management of compulsive rituals, the available clinical evidence, although more meager, indicates that treatment should incorporate strong elements of prolonged exposure to stimuli related to the content of one's obsessions. This is most often accomplished by developing "public" stimuli of the patient's intrusive thoughts, images, or impulses. Examples include having patients make tape recordings of their obsessions, writing down their obsessive thoughts, or reciting the feared material aloud. Variations include assembling photographs or

videotapes related to anxiety-evoking thoughts. For example, a mother morbidly preoccupied with fears of poisoning her children would be asked to gather newspaper clippings about the prevalence of salmonella in everyday foods, about mass poisonings in restaurants or during family reunions, etc.

These anxiety-evoking stimuli are used to purposively "satiate" the patient through repetitive prolonged exposure in a manner analogous to that employed in treating the ritualizer. The obsessive may be asked to intentionally set aside time each day to listen repeatedly to an audiotape (made in his or her own voice) of intrusive thoughts; to state aloud intentionally supressed covert curses, obscenities, or imprecations; or to provoke such thoughts, images, and impulses by deliberately exposing oneself via media stories and pictures to materials that provoke obsessive ruminations.

The above tactics are based on experimental evidence that covert events such as obsessions are subject to habituation in a manner similar to that obtained with overt behavior (e.g., Parkinson & Rachman, 1980; McCutcheon & Adams, 1975) and on other relatively favorable evidence obtained to date. Table 1 lists the pertinent clinical outcome studies which bear on this matter.

Clearly there is some empirical justification for attempting to treat obsessional patients using exposure-based methods that parallel the treatment of compulsive ritualizers. However, given the relative rarity of such cases for the foreseeable future, the clinical research literature will likely continue to be dominated by single-subject studies of the treatment of purely obsessional patients. We describe below a further contribution to this field conducted by social workers.

CASE HISTORY

The patient was a 50-year-old married white male who presented at the Anxiety Disorders Program with complaints of repugnant and blasphemous thoughts. These intrusive thoughts, which numbered approximately 10, were mostly brief phrases explicitly describing sexual relations between Jesus Christ and the Virgin Mary or other negative phrases against religious figures (e.g., "Lord's penis in the

TABLE 1
Summary Listing of Favorable Studies on the Exposure-Based Treatment of Obsessive Patients

Boulougouris & Bassiakos (1973)
Broadhurst (1976)
Crook & Charney (1982)
Emmelkamp & Giesselbach (1981)
Emmelkamp & Kwee (1977)
Farkas & Beck (1981)
Fisher & Winkler (1975)
Hackman & McLean (1975)
Headland & McDonald (1986)
Likierman & Rachman (1982)
Meyer (1966)
Milan & Kolko (1982)
Rainey (1972)
Salkovskis (1983)
Singh & Oberhummer (1980)
Sookman & Solyom (1977)
Stambaugh (1977)
Stern (1978)
Thyer (1985)
Vogel, Peterson, & Broverman (1982)

NOTE: Some listed studies employed multiple interventions.

Virgin Mary"; "The Virgin Mary is a whore."). A clinician skilled in the use of the Diagnostic and Statistical Manual of Mental Disorders (third Edition, DSM-III) arrived at a diagnosis of obsessive compulsive disorder based upon the then current criteria (APA, 1980). Unlike the majority of such cases, the patient did not report any compulsive rituals associated with his obsessive thoughts, and he did not meet the criteria for any other DSM-III disorder.

The patient dated the onset of his intrusive thoughts to an event that occurred when he was 27 years old. While delivering a lesson to a classroom of grade-school children, he suddenly experienced a blasphemous thought about Jesus Christ. The patient became very distressed about this thought and subsequently began to experience other intrusive thoughts containing increasingly greater amounts of distressingly graphic blasphemous content. Consequently, for over 20 years prior to his seeking treatment with the Anxiety Disorders Program, the patient suffered marked discomfort on a near daily basis. He had previously received rigorous trials of supportive and dynamically oriented psychotherapy over eight years with three different clinicians. These treatments did little to reduce the frequency or duration of his obsessions or the associated subjective distress. He also had received a short-term trial of Triavil (at an unknown dosage) that was also ineffective.

TREATMENT

Formal treatment sessions were initially conducted once per week and then once every other week. Treatment consisted of a three-part program aimed at exposing the patient to the content of his intrusive thoughts. A list of the obsessions, which took the form of brief phrases, was obtained from the patient; this effort required a great deal of encouragement, shaping, and support because revealing them in explicit detail to the therapist was greatly distressing to the patient.

In accordance with the program described by Thyer (1985), the first of the exposure therapy tasks consisted of having the patient listen to a supervised recording of himself repeatedly reading the phrases aloud in a clear voice. The second portion of the exposure therapy program

consisted of having the patient repetitively read aloud a list of his obsessional thoughts. The final daily exposure therapy task consisted of having him repeatedly write out his list of instrusive thoughts.

The written exercises were completed five times daily for 15 weeks and were then discontinued because of the amount of time required for their completion and the fact that they were no longer distressing to the patient. The oral and audiotaped exposure exercises were repeated 10 times daily for 7 weeks and then reduced to five times daily until the middle of week 17, when they were terminated by mutual agreement.

The outcome measure employed to evaluate the effects of this exposure therapy regimen consisted of having the patient record daily his peak levels of subjective units of distress (SUD) engendered during each distinct therapeutic task (oral, written, and audiotaped). This method of quantifying anxiety levels, which was initially developed by Wolpe (1973), consists of the patient's self-rating of distress using a subjective scale on which zero = complete calm and 100 = terror/ panic. Such SUD scores are known to correlate moderately well with several measures of autonomic arousal (Thyer, Papsdorf, Davis, & Vallecorsa, 1984) and are commonly employed in clinical research and practice with anxious individuals.

The purpose and rationale of the treatment program was thoroughly explained to the patient, and the importance of consistent compliance with the exposure therapy exercises and maintenance of SUD records was emphasized. Daily SUD scores were recorded on a simple form provided to the patient.

RESULTS

The effects of intentional, prolonged, and repeated exposure to the content of obsessional thoughts with this patient are depicted in Figures 1-3. Each data point represents an average daily SUD score for the given exposure task (i.e., listening to the audiotape, writing the phrases, speaking the phrases aloud). This average daily score was obtained by summing the actual SUD for each exposure trial and

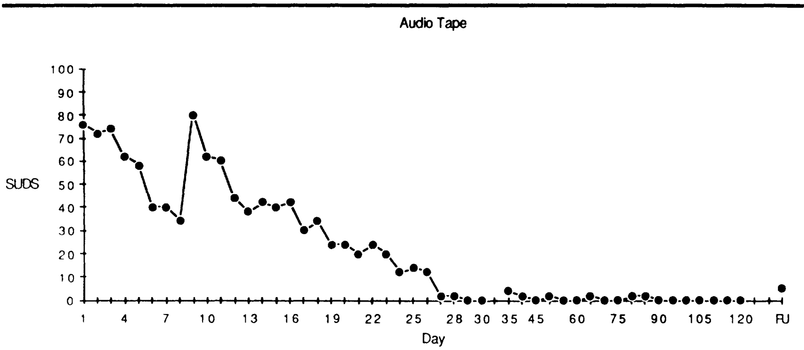

Figure 1: Daily Peak SUD Scores Experienced while Repeatedly Listening to the Audio-Tape Recording of Obsessional Ruminations.

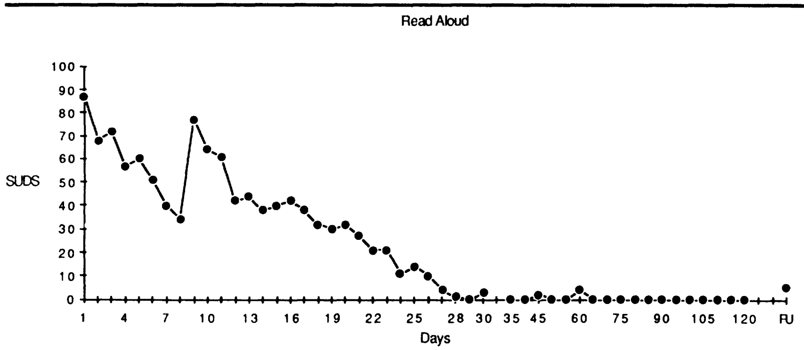

Figure 2: Daily Peak SUD Scores Experienced while Repeatedly Reading Obessional Ruminations Aloud.

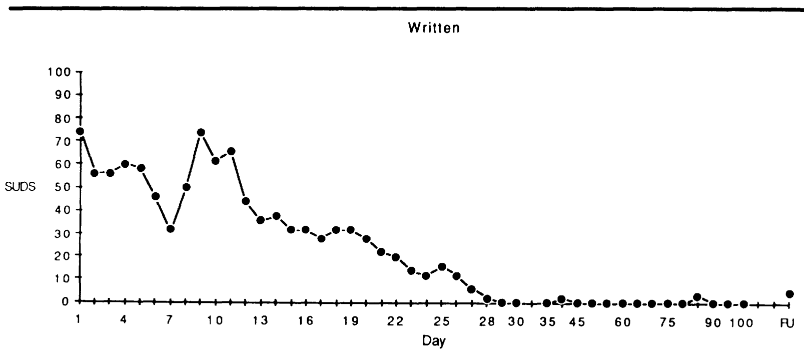

Figure 3: Daily Peak SUD Scores Experienced while Repeatedly Writing Obsessional Ruminations.

dividing this total by the number of repetitions that day, thus obtaining a daily mean score for that specific exposure task.

After reporting intense feelings of anxiety on the first day of exposure practice, with average SUD scores being 76, 87, and 74 for the audiotape, reading, and writing tasks, respectively, a pattern of gradual diminutions of anxiety is apparent. One exception to this pattern occurred on day nine of the program, when a temporary increase in SUD scores was experienced as a result of the appearance of a new intrusive thought. This type of event did not repeat itself throughout the remainder of treatment, but the fact that the new obsessional thought was easily incorporated into the exposure program and was subjected to the same process of habituation illustrates the flexibility of the therapeutic regimen.

By day 30 of the treatment, the average SUD score for each type of exposure task had been reduced to near zero. At this point, the patient reported a concommitant and dramatic decrease in the frequency of spontaneous obsessional thoughts and in the distress engendered by their occurrence. This was the first remission of obsessions and clinical anxiety the patient had experienced in over 20 years. The few obsessional thoughts that did occur following the first few weeks of treatment were reportedly easily dismissable and no longer upsetting. The exercises were continued for approximately three more months, with little change in the average levels of subjective distress. At the end of the exposure therapy program the patient was essentially free from obsessional phenomena.

The patient has continued to report being almost completely free of intrusive thoughts at two-year follow-up. The rare occurrence of blasphemous thoughts engenders little anxiety. A probe trial of the original exposure tasks conducted on a one-day basis two years after the beginning of treatment yielded SUD scores of near zero for the audiotaped, recitation, and written procedures.

DISCUSSION

The results of this case provide further evidence that a treatment of choice for obsessional patients consists of a structured program of

prolonged and repeated exposure to stimuli, otherwise avoided or suppressed, that relate to obsessional ruminations. Unlike earlier studies, multiple presentations of obsessional materials (through listening, writing, and reading) were employed, which learning theory suggests will promote the generalization and maintenance of therapeutic changes. Our positive findings at two-year follow-up appear to be the most lengthy posttreatment period reported among clinical research studies with this population. We believe that the conduct of control-group studies examining the exposure treatment of obsessives is now justified and called for.

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